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ABSTRACT

This document presents witnesses' testimonies and related materials from the Congressional hearing called to consider how the federal government can better meet the health needs of the homeless. Opening statements are included from Congressmen Henry Waxman, Ron Wyden, and Gerry Sikorski. Witnesses providing testimony include Robert Gallagher and Delores Marshall, two residents of shelters for the homeless. William J. Vicic, St. Vincent's Hospital, New York City, tells from clinical experience the health needs of the homeless. Phyllis B. Wolfe, Health Care for the Homeless Project, explains how the Washington, D.C. project set up a new delivery system to reach the homeless. Diane Sonde, Project Outreach, Goddard-Riverside Community Center, New York City, explains how Project Outreach makes contact with the chronically mentally ill homeless and makes mental health services available to them. Also providing testimony are Janet Waxman and Tipper Gore, co-chairs of Families for the Homeless, who discuss recommendations concerning the federal-state Medicaid program and provisions of the Health Care for the Homeless Act. Maria Foscarinis, Washington Counsel for the National Coalition for the Homeless, emphasizes the need for the federal government to take action to meet the health care needs of the homeless. Materials submitted for the record, prepared statements of witnesses, and question and answer dialogues between committee members and witnesses are included. (NB)

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HEALTH CARE FOR THE HOMELESS

ED289100

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

DECEMBER 15, 1986

Serial No. 99-182

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HEALTH CARE FOR THE HOMELESS

MONDAY, DECEMBER 15, 1986

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to call, at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

This morning the subcommittee will consider how the Federal Government can better meet the health needs of the homeless?

It is embarrassing—but obvious—that the Federal Government has no coherent strategy for meeting the needs of the homeless in general, much less for meeting their medical and mental health care needs in particular.

Over a year ago, the Congress passed, and the President signed, legislation directing the Secretary of Health and Human Services to request the National Academy of Sciences to study the delivery of health services to the homeless.

We had hoped that this study would provide us with some recommendations for Federal action. Unfortunately, due to Departmental delays in securing funding, the study did not begin until the beginning of this month, and we will not have any findings until the end of next year.

However, we simply can't wait any longer. By all accounts, the number of homeless continues to grow, especially the number of homeless families. Despite the efforts of the private sector and some localities, many of these men, women, and children have serious health needs that are not being met.

Last year the Congress passed, and the President signed, a number of changes in the Medicaid program for the poor designed to make it easier for homeless people who qualify for Medicaid coverage to actually receive their benefits.

Last June, my colleague, Mr. Leland, who has been a leading champion for the homeless in the House, introduced the Health Care for the Homeless Act, H.R. 5137. This legislation would make funds available directly to public or private non-profit organizations to deliver outpatient health and mental health services to the homeless. Unfortunately, the Congress did not act on this bill.

Today's hearing is not on specific legislation, however. Instead, we are asking four broad questions:

One, what are the medical and mental health needs of the homeless?

Two, how are those needs currently being met, if at all?

Three, what are the most effective ways of delivering health services to the homeless?

And four, what role can the Federal Government play in improving the access of homeless people to needed health services?

I recognize, as do all the Members of the subcommittee, that Federal resources are limited. Given the intense pressure to reduce the deficit, it will simply not be possible for the Federal Government to meet all of the needs of the homeless, or even all of their health needs, next year.

But we cannot let the Gramm-Rudman deficit targets—or Ronald Reagan's tax allergies—paralyze us. There are some steps that the Congress can—and should—take to strengthen and expand existing private and public efforts to meet the health needs of the homeless. This hearing will, I hope, point us in the right direction for action on legislation early next year.

Before recognizing our first witnesses, I want to call on my colleagues for any opening statements they might wish to make.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

First, I want to associate myself with your remarks because I think you have said it very well. I think when historians look back at this period, they are going to measure our society not by pet rocks or what was on Entertainment Tonight, but how we dealt with meeting the human needs of our citizens.

This is a particular problem in my home State of Oregon. It seems that the gap in Oregon between the needs and current resources is getting greater and greater and I am pleased that one of my constituents, Michael Stoops, has come to Washington to fight that growing gap. He runs the Baloney Joe's Program in my district to furnish dental services to the indigent. He has indicated that he is going to stay here until justice is done and more attention is focused on the needs of the homeless.

I think, Mr. Chairman, this should be a priority during the next session. It is going to require some rethinking of our present policies.

For example, one that I think we ought to rethink is the whole notion that developed in the seventies about deinstitutionalization.

Many of us supported that effort based on the theory that if people were disinstitutionalized, there would be a great number of community-based services, to fill in; foster care, group homes and others.

But what has happened is that in many communities those kinds of programs have not been available. So our homeless literally have been walking the streets until they hurt themselves or someone else.

One of the things I would like to see us do is rethink deinstitutionalization. We need to guarantee treatment for those released from facilities.

In my home county alone, there are thousands and thousands of homeless right now and I think with respect to this critical area of government, we have got to do better and now is the time.

Thank you, Mr. Chairman for your important leadership.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Sikorski.

Mr. SIKORSKI. Thank you, Mr. Chairman.

I commend you for holding this hearing and for your active work and the work of your wife, Janet Waxman, Tipper Gore, and others, in their efforts.

At a time when holiday cheer is up, the misery index is up as well. We are beginning the winter season. People are dying. Hospitalization rates are up, amputations are up, and steel grates across this country are getting more and more crowded.

Hubert Humphrey said that a society is more than just cold steel. It is, in fact, very much a warm heart. It is our job through your leadership, and I commend you for it, to get the Federal heart pumping so that before this winter season is done, we have taken emergency action to help the hundreds of thousands of homeless across this country to get shelter, basic services for their bodies and their minds, including health care, mental health, and physical help.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

To lead off the witnesses that we have for this hearing today, we are pleased to welcome two individuals who are currently living in shelters for the homeless in the District of Columbia.

Our first witnesses are Robert Gallagher and Delores Marshall. I will ask them to come forward and take seats at the table.

Each of them will tell us from personal experience about the health needs of people on the streets and the importance of health care to their survival.

Thank you both for coming this morning. It is going to be helpful for us to hear what you have to say.

We think it is important for us to know and for others to know as well.

Mr. Gallagher, would you begin?

STATEMENTS OF ROBERT GALLAGHER, THE SAMARITAN INN; AND DELORES MARSHALL, VICTOR HOWELL HOUSE

Mr. GALLAGHER. My name is Bob Gallagher. I am now living at the Samaritan Inn here in D.C. and I am working as a waiter-dishwasher at the Presbyterian Home.

I had never lived on the street before. I am originally from New Jersey and for the past 25 years I have lived and worked in New Orleans.

That work petered out. It was in the oil industry, and I came to Washington because I thought I could find a job here. I couldn't, and that is when I became homeless.

Then through Traveler's Aid, I found out about a labor pool where I could work and I became a day laborer after that, still trying to find a regular job. Then in July of last year, I fell off of a

scaffold while working and I hurt my hand. Then I was out of work.

I was at the time able to get a room in Arlington, but when I got out of work, I wasn't able to pay the rent, so I lost the room.

Fortunately, I had a sleeping bag and it was summertime and I had to live in the park. I turned to drinking to cope with my life and the way things were. I had no medical insurance and I wasn't getting general relief of any kind.

Last December it got very cold and I couldn't breathe and I had trouble sleeping. Because of not having medical insurance or any medical assistance, I decided to go to the VA Hospital because I am a veteran. They kept me in the waiting room for three or four hours and found out there was nothing they could do for me so they sent me back out on the street at 3 a.m.

It took me about an hour to get out of the parking lot up there and I walked all over the city just about fainting and a policeman picked me up and took me to D.C. General. They kept me for a while and figured that I was on the verge of pneumonia. They didn't say I had a fever or anything, so they let me go.

This past February I went to the VA Hospital for the same reason and they did take me in. I stayed for three or four weeks, then they let me back out into the street. I found out about the shelters that are provided here in the city and I decided to take advantage of that.

The two or three times that I did stay at the shelter I was rolled for like a little change I had in my pocket and I was afraid to stay there.

I found a vacant house and went into it and I felt kind of safe. Finally, in February I was out in the street and I stopped breathing. Fortunately a man saw me and called an ambulance and they took me to Howard University where they found out that I had COPD, that is chronic obstructive pulmonary disease. This is caused from living in the elements.

I stayed at Howard University Hospital for 56 days. Over a month of that was in intensive care. There I met a good, compassionate doctor, Dr. Adams, and I talked to him about where I would go from there. I said I had no idea.

He also said that if I would go back out to the streets or even a shelter, that my life would be pretty short. He said, "Well, we are not going to do that. If I have to, I will take you to my house;" that is how good this guy was.

Anyway, he found a place called Christ House which is an infirmary for sick, homeless people. The most they can hold at Christ House is about 38 people, and they try to take care of a person at this critical point when they are discharged from the hospital instead of sending them out into the street.

This place gets them a little stronger where they are able to get by.

At Christ House, I only stayed one week. They found this place called Samaritan Inn, which is a step better.

At Samaritan Inn, they helped me get on to general public assistance. They helped me get well mentally and physically. I was out of the street.

I live there now. It is more than a shelter. It is a home, and you learn to help yourself, not just live off somebody. You learn to get on your feet.

Through the grace of God, I am working now. I have a job, my health is back and I have a lovely home.

I know I won't be there forever, but they are helping me where I can save—we do pay rent there, but I can save to get my own place pretty soon.

I find that we need many more places like that. It is not just a roof over your head. It is a real home where you can go.

I find that so many people, especially in the city don't have that chance I had. I don't know how, it is amazing grace that I had that chance at all. There are so many people that don't come close to that chance.

That is it.

Mr. WAXMAN. Thank you very much for sharing your story with us.

We will hear from everybody else and ask questions after that. Let's hear from Delores Marshall.

STATEMENT OF DELORES MARSHALL

Ms. MARSHALL. Good morning.

My name is Delores Marshall. I am a victim of a hit-and-run accident which occurred on October 25, 1986. I got a fractured hip and a pelvis. When I had the accident, I had been staying at a shelter on Lincoln Road. I was out for 12 hours. I woke up tied to the bed because I was having spasms.

They couldn't X-ray me. I was in traction for 2½ months at Howard University. I was there for three weeks.

I asked to be released because I couldn't pay the bills. When I got out, I went to Lincoln for one day. I couldn't go up and down the steps; I kept falling. At the hospital, they showed me how to use crutches.

After Lincoln, I went to Victor Howell House and am living there now. I was told to call the hospital for follow-up. There was never any answer. It was always busy. I hadn't seen a doctor because they needed an X-ray and I had to go to the hospital for that.

The bill at Howard was $8,500. The bill hasn't been paid because I have no income; I have no Medicaid. I think the hospital should have helped me with Medicaid. I asked them to help me, but they said they couldn't.

Last Friday, the people at Victor Howell House helped me file for Medicaid, but they wanted a statement of unemployment. I can't find employment. My previous employer won't sign an unemployment statement. I still haven't received it and if I don't bring it in this Tuesday, I will be ineligible.

I could get Medicaid if someone would come to the shelter and help.

Right now I can't get pain pills because they are narcotics which aren't given at the shelter. I am taking Motrin, but it is not strong enough.

At the hospital, they say to stay off my feet for three weeks. I have been living in a shelter since that summer because before then I was staying with friends.

It has been two years since I had my own place. I was evicted because I couldn't pay the rent. I was working at the time. I worked nights at a club and I worked days as a shampoo girl. Then I started going to school for auto mechanics.

After that, I wasn't getting financial assistance because I was taking on jobs like cleaning, but it wasn't enough to get my own place.

I have two kids. They are in a foster home. They have been in a foster home for two years. I put them there and thought it would be better. I wanted to give them a good education. I wanted them to have a better chance.

My son is 11 and my daughter is 5. I haven't got transportation, so I can't see them. I talk to them on the phone.

Now I have no income, but I applied for public assistance. With general assistance, you get $220 a month. I cannot live on that. The cheapest room is $250.

Mr. WAXMAN. Thank you very much for your testimony and for sharing with us a very painful, personal situation. I hope your testimony will help us handle things better for other people.

Let me ask you, Mr. Gallagher, you are a veteran, so you have some health care available to you as a veteran; is that right?

Mr. GALLAGHER. Yes.

Mr. WAXMAN. The story you told us about the kinds of health care you have been able to get from the veterans' institutions, wasn't very encouraging. Do they have health resources there at the shelter you have been involved with or seen? Do they have doctors or nurses or other health professionals to take care of people?

Mr. GALLAGHER. Not right in my home, but we do have it available at Christ House that is sort of affiliated with this place. However, Christ House holds only 38 people at the most and I am sure they are understaffed. They do have, I think, four doctors on their staff to take care of people. They have started a program where they go out with the food wagon that goes to different parts of the city and feeds homeless people with soup or sandwiches or something.

Christ House has started sending a van out with these wagons to try and meet the immediate medical care that some of these people might need. However, I know they need more doctors and more help, definitely.

Mr. WAXMAN. It sounds like Christ House has been a real blessing to you and to the others there who have helped by it. How many homeless people are there?

Mr. GALLAGHER. At most—they have 38 beds, I believe.

Mr. WAXMAN. So a relatively small number of people when we look at the numbers of people—

Mr. GALLAGHER. That are homeless, yes.

Mr. WAXMAN. Very few have an opportunity to be served by Christ House as such?

Mr. GALLAGHER. Yes.

Mr. WAXMAN. Christ House is a private organization affiliated with a church?

Mr. GALLAGHER. It was started by the Church of the Savior that is an ecumenical church here in the city. I don't believe it is run by private funds, however, mostly donations by their parishioners, I guess. A few of us have done little things to donate money; like I make quilts and I made four of them and took in about $650, but that is enough to buy a box of toothpicks compared to the size of the group.

Mr. WAXMAN. You have the ability to go to Veterans' Hospital if you are sick. If you weren't a veteran and you didn't have that health care coverage, would you be able to get health care?

Mr. GALLAGHER. No. I have only been at the Presbyterian home for a month now and we have no insurance at all. Maybe after three months, they will get us in on something.

Mr. WAXMAN. That is a fact of life people who are working at low-income jobs. There is no health insurance furnished by their employers, so they don't have coverage at all.

Mr. GALLAGHER. That is what happened to me last year when I fell off the scaffold. Just a simple thing; I sprained my wrist so I couldn't find work, but I couldn't get medical help either. They had X-ray coverage for my hand.

Mr. WAXMAN. Ms. Marshall, when you had the auto accident, where were you able to go for medical services?

Ms. MARSHALL. I haven't seen a doctor since I got out of the hospital. I was at Howard University for three weeks, but I haven't been back to another doctor.

Mr. WAXMAN. They still have a bill for you to pay which you haven't been able to pay?

Ms. MARSHALL. Right.

Mr. WAXMAN. So it wasn't free services? It was services where you will owe them money?

Ms. MARSHALL. At the shelter there are free services. But they don't have X-ray machines and the only way you can see whether progress is being made with my case is having an X-ray machine. You can't just feel, touch, anything like that. You have got to actually see the bones where the breaks were made.

Mr. WAXMAN. Since you left the hospital, you haven't been able to go back to a doctor to get follow-up care to see how you are progressing?

Ms. MARSHALL. Right.

Mr. WAXMAN. That is because you can't afford it?

Ms. MARSHALL. Right.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Just a couple of questions if I might.

Thank you both for a very, very courageous and thoughtful presentation.

What you have here are three Members of Congress who very much want to devise a new system for making sure that homeless people can get medical services.

I would be very interested in your suggestions to help us come up with a system to make sure that homeless people would get needed care.

What do you think would work best at this point? Either one of you.

Mr. GALLAGHER. That is a good question because I was fortunate enough to go to this place called Christ House. It is the only one that I know of in the city, and they tell me that when a person is discharged from a hospital, any hospital, that is a critical point in their life, where they should go home if they have one and rest for a week or so until they are able to go back to work or whatever.

But people who are homeless and have no medical insurance or anything, when they are discharged from the hospital, they are sent out into the street in this critical point, and that is it, and they just get worse or die, whatever, or they might be able to take care of their—get their medicines and all if someone would help them to get on Medicare or Medicaid, maybe they would be able to get their medicines, but in the position they are in and the state of mind that they are living in in the streets and all—I know I wasn't responsible enough to even take my medicines when I was supposed to.

My main thing was just living, where can I get something to eat and at that point where can I get a drink. This one place, Christ House, you know, they are understaffed, they only have four doctors. If it was possible to open up such places here and there in different cities, it would be great.

Mr. WYDEN. Ms. Marshall.

Ms. MARSHALL. Like the situation I am going through, there is a lot of machinery that is needed in the shelters that should be provided for them so people who need these things, they can come up and be able to have them right there.

Maybe if somebody would go out and let the hospital—go see what they have at the hospitals that possibly could be used in a shelter and that was complex enough where they have a place for it, then that would be nice.

Like my pain pills, even though they are narcotics, with the facilities, if they had them where you didn't have to pay an arm and a leg for them or go without them, that would be sufficient, and if they were—like we have one doctor that comes to the Victor Howell House and he only comes on a monthly basis.

If he could come on a weekly basis or a nurse that could visit on a weekly basis and open up more free places where you can get better medical help.

Mr. WYDEN. Those are excellent suggestions, and looking at ways to get more equipment into the shelters is one thing that I know we are very interested in and maybe would have helped in the X-ray situation you were talking about.

I also appreciate your point about that critical time when someone is released from a hospital and still isn't well. We need to provide services in communities for our needy.

I have just one other question for both of you and something that is a problem for all medical care, but it seems to me to be a particular problem.

I sense that because many homeless people can't get medical care that when they have a serious medical problem, they can't get treatment and it just gets worse. Finally they are literally in a situation where they have to go to the hospital emergency room for care when if it had been treated earlier, when it was treatable.

Are you all finding that people who are homeless have these serious medical problems and just put them off in the way that I have described it?

Mr. GALLAGHER. Yes, sir, because it happened to me when I went to the VA Hospital last December. They found out there was nothing they could do. I was on the verge of pneumonia, but there was nothing they could do and they figured it is not my fault you live in the streets; they said good-bye at 3 a.m. in the morning and it happened to be very cold and I walked and walked until a policeman—he probably thought I was drunk—he said, "I will take you to a hospital."

He took me to D.C. General, but I didn't get medical care then. The only thing is he gave me a ride around the city until the sun came out and my disease, the pneumonia got worse and worse.

Mr. WYDEN. Ms. Marshall, did you want to add anything to that?

Ms. MARSHALL. What I was thinking—because you can't pay the bills and like myself, I don't feel that—they keep mounting up, the bills, and keep mounting up, and not being able to pay them is fair, so why should I go to a service and make bills? Eventually somebody is going to come to my door and get me for all these bills that I can't pay.

So why go? Why not try to deal with that problem like it is?

Mr. WYDEN. I think, Ms. Marshall, you said it very well; that people who have these serious problems are living with them and they get worse and later on it is much harder to help them get better and more expensive and everything else.

I thank you both and thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Sikorski.

Mr. SIKORSKI. Thank you, Mr. Chairman.

One comment and if the panel would like to comment—I, too, would like to thank you for coming here this morning. I think your testimony graphically illustrates that there is a direct economic—not social or societal, but direct economic cost to homelessness and to the situation of health care that is provided on an emergency, relatively lengthy, acute care basis after a condition has gone to the point where that is the only appropriate response.

Mr. Gallagher talks about how he was a few weeks at VA Hospital, at three o'clock in the morning they dumped you out into the parking lot. Then you spent a week at D.C. General, I guess, and then you spent 56 days at Howard University, and I don't know what the total cost is, but my guess is around $40,000 to $50,000 for that hospitalization, and this came about after you sprained a hand and then were forced into living in the elements; forty or fifty thousand dollars I would guess at minimum to the health care system, absorbed there, because of the inability to have a health system that responded earlier, an inability to just deal with the question of homelessness.

Ms. Marshall talks about 2½ weeks here in the hospital and then an inability to fully recover, get back on your feet, get back into a paying situation with some kind of health benefits, hopefully, and just an impossibility to get on top of bills that through no fault of your own were so great that there is no incentive to mount them.

In both cases, you have good examples of the economic cost to society of homelessness, economic cost, and the economic cost of a health care system that only comes in at the end on an acute care basis, in an emergency basis, and when it is forced to.

It is a very expensive system, and we can do better for people and better for our pocketbooks if we take to heart your testimony this morning.

Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

We do appreciate your being here to share with us your own experiences. It was really important for us to hear once again that if you don't get health care treatment early enough, you are going to get sicker. It is clear that society is at some point going to pay the bill and that we are going to pay a bigger bill than would otherwise be the case if we delay giving services to a population as vulnerable as the homeless. What is our moral obligation to each other?

Letting people go without care is the wrong thing to do. If that is our answer, we have to try to figure out some solutions.

Those solutions will cost money, but if those needs are not being met, it seems to me we have to devote resources to meeting them.

Thank you very much for being with us this morning.

Our next panel will consist of three individuals involved in the direct delivery of services to the homeless. Dr. William J. Vicic is an attending physician at St. Vincent's Hospital in New York City. Not only does St. Vincent's deliver services to the homeless, but it also administers the national program of the Robert Wood Johnson Foundation and the Pew Memorial Trust which funds delivery of health services to the homeless in 18 cities throughout the country.

Dr. Vicic will tell us from his own direct clinical experience about the health needs of the homeless.

Phyllis B. Wolfe is the Executive Director of the Health Care for the Homeless Project in Washington, D.C., one of the 18 cities of the Johnson-Pew Foundation program.

She is also a member of the panel established by the Institute of Medicine to carry out the congressionally mandated study of health services to the homeless.

Ms. Wolfe will explain how the D.C. project, using a combination of public and private resources, set up a new delivery system to reach the homeless.

Diane Sonde is the Director of Project Reachout based at the Goddard-Riverside Community Center in New York City.

She will tell us how her organization is able to make contact with the chronically mentally ill on the streets and assure that needed mental health services are made available to them.

Dr. VICIC. We want to welcome you to our hearing. Your prepared statements will be made part of the record in full so you don't have to worry about reading every line of it. We would like to ask you to summarize your statements if you would.

STATEMENTS OF WILLIAM J. VICIC, ATTENDING PHYSICIAN, DEPARTMENT OF COMMUNITY MEDICINE, ST. VINCENT'S HOSPITAL; PHYLLIS B. WOLFE, EXECUTIVE DIRECTOR, HEALTH CARE FOR THE HOMELESS PROJECT; AND DIANE SONDE, DIRECTOR, PROJECT REACHOUT, GODDARD RIVERSIDE COMMUNITY CENTER

Mr. VICIC. Thank you.

My name is Bill Vicic. I work as an internist for St. Vincent's Hospital and and all my patients are homeless individuals.

I have worked in this job for four years and I must not let you think even at the outset that I work by myself.

I am a member of a rather large team, about 20 individuals strong, who go out into the field every day mainly at shelters in New York City and welfare hotels in New York City and the team includes physicians, social workers, nurses, and other health care providers, including administrators who are awfully important in terms of getting programs going.

One point I would like to ask you to remember throughout these hearings is that the illnesses that homeless people are subject to are the illnesses that you and I are subject to. They are the illnesses of all of us in this room.

It is the setting or the context in which these illnesses occur which is different and which lends a strong sense of urgency to their health care needs.

By that, I mean that the homeless person has to cope with illness without the benefit of home care, without the benefit of family support or the support of friends and often in the setting of a very difficult access to medical care. There is no ready money available for medications, emergency room waiting times and even public health clinic waiting times are extraordinarily long, and once again there is a lack of social support even when medications are available and even when clinic appointments are made.

This can come down to such simple questions as how will the transportation from wherever this homeless person is to the health care system be arranged? Will it be adequate for a person who has a cast on his leg or who needs a wheelchair?

These are simple questions, but they come up and they as much as anything else prevent a homeless person from getting the kind of health care that is timely and appropriate.

The most common health care needs that we see in New York City among homeless individuals include infections, most commonly among them respiratory infections, especially at this time of year, but also infections which come from being exposed to the environment and not having adequate access to hygiene, so that skin infestations and tissue infection are daily occurrences.

Trauma is another very common source of medical problems for homeless people. Living on the streets or even living in shelters and other substandard housing often exposes individuals to traumatic events, either physical trauma or the kind of mechanical trauma that results from not having an adequate bed, for example, from staying in a chair for too long a period of time, sleeping on a bench.

The problem of assault or attack on city streets, subway stations, in transportation waiting rooms, is always a danger to homeless people and it is something with which they contend on a day-to-day basis.

It is this sort of thing, the dangerous lifestyle that homelessness is, the unpredictability that it carries with it, that is inherent in it, that when one encounters persons such as we saw with the individuals on our first panel today, we understand that homelessness loses and trace of romance.

There is none of the heady adventurousness of a life in the open spaces on the road and there is all of the despair of not being able to provide for one's own needs.

Other chronic illnesses commonly seen by us at St. Vincent's include diseases of the cardiovascular system. High blood pressure is extraordinarily common among homeless people in New York City, occurring in as many as one-fourth of the individuals we see.

Heart diseases in other forms, including heart failure, is frequent and the sometimes delicate management of heart failure by multiple medications and diet is difficult for a homeless person.

Other major problems such as tumors, most benign and malignant forms of cancer, and infections that may be related to a debilitated state, unusual infections, not the common ones, are seen in homeless people.

We see major illness often, and this is frequently the critical time which would lead a homeless person to be hospitalized. And then the cycle tends to repeat itself, because once the health care system in the hospital is activated so to speak, and the chance for repairing or regaining health is there, but the homeless person then faces the same homeless situation on leaving the hospital.

There is no place to go. There are pieces of paper which signify prescriptions, but no actual medications. There are instructions as to how to care for oneself, but there are no facilities with which to follow those instructions.

So we are attempting at St. Vincent's to do two things: to first of all reach homeless people by going out into the streets and into shelters and into hotels, and then to get to know them and I mean by that not only on a personal basis which we do, but to get to know the kinds of illnesses, and the kinds of health care problems frequent and common in homeless people and then to know further. How a homeless person can come to interact with the health care system that we have already set up.

Outreach is certainly part of the approach. A clinic at the hospital established especially for homeless people is another. And various model systems which I hope will be forthcoming from the 18 Robert Wood Johnson Memorial Trust cities may be a third and hopefully all these will provide ways to interrupt the kind of inconsistent and inadequate care which is typical of the health services which homeless people experience.

Thank you.

Mr. WAXMAN. Thank you very much.

[Mr. Vicic's prepared statement follows:]

HEALTH CARE
FOR THE HOMELESS
PROGRAM

St. Vincent's Hospital
Dept. of Community Medicine
153 W. 11th Street
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Philip W. Brickner, M.D.
Director

Stephen L. Wobido, C.S.W.
Deputy Director

Date: December 10, 1986

To: Subcommittee on Health & the Environment

From: William Vicic, M.D.
Attending Physician
St. Vincent's Hospital
New York, New York

Homeless individuals experience all the illnesses common in all human beings but their health needs acquire special urgency because of difficult access to medical care and because of inadequate and unreliable housing. Typically, disease among the homeless is treatable but treatment is complicated by their inability to comply with prescribed therapies (No regular transportation to medical centers, no money for medications, extraordinary waiting time in emergency rooms and hospital walk-in clinics). Chronic illness is exacerbated by exposure to the vagaries of weather, by physical trauma on the streets, and by the sense of distrust and anger generated in a life of isolation. These harmful aspects of homelessness apply to both individuals and, alarmingly, to families forced to live in an insecure, disconnected environment which separates them from enfranchised society. Approaching the problem of health care in the homeless necessitates addressing several facets of homeless existence - housing and social integration are indeed matters of health. Medical outreach programs which incorporate general medical care and psychiatric care must be established in parallel with efforts to provide affordable and appropriate living quarters.

Mr. WAXMAN. Ms. Wolfe.

STATEMENT OF PHYLLIS B. WOLFE

Ms. WOLFE. I am Phyllis Wolfe. I am delighted to be here this morning. I am the Executive Director of the Health Care for the Homeless Project in Washington.

Today marks the beginning of my sixth year working with the homeless. I started December 15, 1981 with a mental health project and I am glad Diane is here.

I spent 3½ years working with the Mental Project and I also at the time became the chair of the local coalition for the homeless and that is when we wrote the Robert Wood Johnson grant.

So it is very interesting to watch, to have a historical perspective on the changes that have occurred and it is also significant to note that the mental health aspects that Diane will speak about, I thought that I had somewhat conditioned myself to deal with people who were in mental health crises and the pain they were going through, but it is another issue to deal with the crises and the pain of the medical health problems, because they are really three-fold, those with some kind of illness or accident that precipitate them going into the population with a medical problem—homelessness exacerbates that problem.

There are also people who have health problems that were not necessarily acute or chronic, but surfaced because of their homelessness, and it is impossible to handle that. Then there are other people who are suffering both. It gets to a situation where it really escalates.

I think I need to speak a little bit to the Robert Wood Johnson Foundation Pew Memorial Trust because they have made a major private sector impact and also at the local sector, because it is truly public-private initiative.

In 1984, an RFP was circulated by Robert Woods Johnson to 51 cities. It was initially 50 of the most populated cities and then they added Puerto Rico because Puerto Rico was saying we have a problem, too.

The development of the proposal required a process where a coalition was formed of public, private entities in every city that applied.

This coalition became the cornerstone for many of the projects later implemented, because it was the first time that any major foundations—and I think they aren't lauded enough for taking the risk of investing $25 million into a problem.

It is a very difficult kind of problem to get a handle on. Initially when they said we are going to fund health projects, the providers started screaming, "What about the mental health?" and they said we have limited resources, so we must address the health issues.

They did, but they encouraged the linkages and the initial funding base of $1.4 million for four years allowed many of us to leverage services and I will tell you what we have done in Washington with that.

I think it is also important that in 1981 the word from the Federal Government was that the volunteer sector should be taking care of this problem.

I remember initially I was working with a local volunteer agency and we had a District Government contract, but it did not cover all the costs that were going on and all the services provided and at that time it was the volunteer sector, the religious sector that was holding the brunt of and providing the most services.

It is still true.

We have had Federal interventions with FEMA money, which is emergency shelter and food. We have had research out of NIMH and NIAAA and a few demonstration programs that people have developed with moneys allocated in different areas, but there has not been a major effort by the Federal Government to impact homelessness, and it is a national issue.

There is kind of two key issues; one, every homeless person needs a home. If they had that home and it was low cost and affordable, then they would not have the issue of homelessness to deal with, which impacts every other aspect of their lives.

They might have other problems, but they would not have homelessness.

The second thing is health and mental health, and I think the two witnesses initially gave vivid descriptions of what happens.

One of the critical issues of health care is access, and in Washington—I am to speak to some of the things that are happening in Washington—it is not only health care to the homeless.

SOME, So Others Might Eat, is an ecumenically run non-profit organization that has a soup kitchen, with a medical services component and a dental component.

They see very sick people, many of them homeless every month and the physicians Mr. Gallagher alluded to are the same physicians that work with health care for the homeless, the Columbia Road Physician Group, and they dedicate their lives to providing health care to the poor and indigent and the homeless.

They have been seeing many sick people at SOME, but it was not until we put health stations in six shelters in Washington that we began to see the really ill homeless, those people who were not able to get to another facility, those people who by virtue of being homeless were dealing with survival on a day-to-day basis and, therefore, their health needs, preventive or whatever, were not addressed.

You might know that you need to get to a doctor tomorrow morning, but you don't know what happened the night before. You don't know what the weather is going to be like, who hit who, who had a psychotic episode in the shelter.

You never know from minute to minute what the situation is going to be and one of the things that slips is health care. We have access through health stations and we have access in another public-private partnership with the District Government in conjunction with Disabled Veterans of America.

They have donated the van Mr. Gallagher mentioned to the city and the District and the District Department of Human Services contributed with health care for the homeless.

So we now have a third mobile team. We did have two going to the shelters. This third mobile team now goes to the streets and grates in the parks and to the First Congregational Church which is a soup kitchen for women, many of whom do not stay in shelters.

These are women on the streets. Sometimes they go to emergency shelters, but most often they are a difficult population to get a handle on, so we spend some time twice a week there in the evening and we provide in the evening until 9 o'clock the opportunity for any shelter provider to call and have a consultation with a physician who is there in the evening to see if there is a need to bring a patient to Christ House.

I will tell you a bit more about Christ House. We need a lot more Christ Houses, where our project offices are based.

Where our project office is based, our project office and mobile team staff work out of Christ House, and in the evening the only access to health care information that shelter providers have is through emergency rooms. They can send a person to an emergency room, and we all know that that is a very costly way to make an assessment.

While we transport or the shelter provider can bring a person that needs to be assessed to Christ House, and they can have a full examination and a determination can be made whether they need to go to an emergency room or whether they can stay at Christ House or whether they can return to the shelter with medications and instructions, so that that is our respite care. That is our mobile out reach.

We have our health stations, we have mobile out reach. We link people to some of the community-based clinics that are available for ongoing care as well as some of the District ambulatory care facilities we are trying to link people to especially those with Medicaid. One of the barriers is access. The city is committed to providing free health care to all that are in need, but by virtue of regulations you must post sliding fee scales, and so people go into the ambulatory care setting and they look up and they see the fee scale and they walk out.

The third tier is hospitals. People have to be linked to hospitals for ongoing care, and there are a number of different hospitals in Washington that provide opportunities at Howard, G.W., at D.C. General, but all of them are being burdened with the health care for the uninsured, and in Washington we have a large undocumented alien population, and we have as Mr. Gallagher mentioned a large population—they estimate it at 100,000; I believe it is much larger than that—of people that work in companies, businesses, agencies with under five people in there, therefore not covered by medical insurance. There are lots of people in Washington doing that.

The final in the tier of services is respite care, and that is what Christ House is. It is the 38 beds Mr. Gallagher mentioned. It has one of our health stations. It is where our mobile team works out of, and it is a place for people to be who are too sick to be in shelter and not ill enough to be in hospitals. What is happening, though, is that because of the economy of the hospital administration at present, a lot of people are being discharged inappropriately to shelter. If they were at home with appropriate care, and they had home health care aides and families to support them, they might be able to make it. But shelter is a totally inappropriate place to be with crutches or a Foley catheter or a bed cast—and we get all of those.

There is a mixed dilemma as to whether the hospitals should discharge, but then there are reasons to say that they should, and there is no place to put them, so it goes on. So I think I support Mr. Gallagher, clearly, that one of the major needs is for respite care, and if on the Federal level I can pull together 18 other cities, because Newark, New Jersey, is part of the Robert Wood Johnson funding and each and every one of them would support the notion of respite care.

You find once you work with the population there needs to be some place that is in between the hospital and the shelter, to take care of people, to allow them to convalesce.

Some of the things that have happened besides our contract on mobile outreach, we have another contract with the District Government that is to provide advocates to work to get people their entitlements. SSIS and SDI are the main entitlements, and we have people who are working, hopefully, to develop some cases where initially people would not appear to be sufficiently disabled to receive SSI, but by virtue of being homeless and having multiple small illnesses, hypertension, multiple illnesses that are not necessarily deemed disabling by SSI, but they have several of these illnesses, we are trying to move to get some of these people packaged properly and with the appropriate medical information, so that they are able to receive these.

We have also G.W. Lab; G.W. University does some of our lab work. We have two health care networks that are to be lauded.

They are both religious groups, the Archdiocese of the Inner Faith Conference, they are going to be collapsing. There are over 200 physicians, many of them specialty physicians, who provide pro bono consultations on homeless people. There is an intricate network where the confidentiality of the physician is guarded and if they choose to see two homeless people a month or five a year, whatever it is, that is maintained, and we matched people who are in need with specialty consultations.

Local foundations, Agnes E. Meyer and Public Welfare, have supported our efforts, so that in each city—and Washington clearly is not a unique model—there has been a linkage of responses from a wide range of organizations. For instance, Red Cross crochets hats, mittens and gloves, and makes ponchos. That was important last year in our first year, but it is even more important this year that we have a mobile outreach. They can take something, they can take a hat and probably reduce the potential of hypothermia.

Collectively, the Robert Wood Johnson Foundation and Pew Memorial Trust have forged truly a private-public partnership that works. We have seen over 1,200 people this year. We anticipate that it will at least be 1,500 by the end of 1986. In the future, we have four-year funding and every project director around the country now is working with their governing board and the city fathers and the state and county to determine the best way to institutionalize the services that we provide.

In Washington that is health, mental health, social services, respite, and outreach. Those are the five service categories, and we are trying to wrestle with it, because the problem, drugs, alcohol, child abuse, and everyone has got their particular constituency, but it is very, very clear that the public-private sector is going to work

to institutionalize these projects, and it would be very helpful if there were some help from the Federal Government to fund either parts of the project. Because it is not like you have to start something new, it is an area that you need to take a focus and say this is a piece of what I would like to do. If respite be the area, and I think everybody would support that respite is an area, that that would be very helpful.

Finally, one other issue is that of the Public Health Service physicians. I have been told that the regs are coming up for review in 1987, and it would be very helpful if the National Health Core doctors would be allowed to work with Robert Wood Johnson projects, both the physician as well as the psychiatrist. I think that would make a major impact with these cities.

Thank you

Mr. WAXMAN. Thank you very much, Ms. Wolfe.

[The prepared statement of Ms. Wolfe follows:]

Testimony

Of

Phyllis B. Wolfe

I am Phyllis B. Wolfe the Executive Director of the Washington, D.C. Health Care for the Homeless Project.

Background

The Washington, D.C. Health Care for the Homeless Project (HCHP) is one of 18 nationally selected programs designed to create innovative approaches in the delivery of health services to a needy and intractable population. The Robert Wood Johnson Foundation (RJF) and Pew Memorial Trust allotted $25 million for this national program. Each of the 18 sites received up to $1.4 million to be used over four years.

The Robert Wood Johnson Foundation initiative was the first major private response to a problem that has been increasing in intensity since the early 1980's. The Foundation's intent was two fold: 1) to provide resources to develop innovative comprehensive programs for the delivery of services; and, 2) to assure that the health delivery services become part of each selected city's comprehensive health delivery system, after the four-year term of the Project.

Each city was required to develop a city-wide coalition of service providers, local government representatives, health care organizations and representatives from the local private sector. In Washington, the twenty-five participants in the planning coalition were representative of all of these entities. The central "working committee" was composed of a member from the foundation community, a direct service provider and four city government staff, who worked in tandem to develop and submit the proposal.

Overview

The primary objectives of the Health Care for the Homeless Project are to initiate, enhance, coordinate, and integrate a community-based service delivery system which can provide greater access to initial and ongoing health care for the homeless. To monitor the progress of the program, and to develop the policies by which it functioned, participants in the planning coalition were selected to form the Governing Board. In addition to setting program policy and providing careful oversight, the Governing Board also is charged with focusing on institutionalizing the effort at the end of four years. The Community Foundation of Greater Washington serves as the fiduciary agent for the Project, providing fiscal oversight to the Governing Board.

The Project has been designed to provide health care, in designated shelters, through the creation of health stations. Health stations are designated rooms in shelters that are equipped and stocked to provide an array of health services and are located in different areas of the city. Mobile teams provide services at the health stations. Patients are referred for full physicals at community-based health centers. Work began on a computerized system of patient information and data collection developed in conjunction with D.C. General Hospital (DCGH).

An extraordinary group of family practitioners and one internist based at Columbia Road Health Services are contracted to provide the health delivery and supervise the staff. There are now three components: two mobile teams who work directly at six health stations; one team that visits several sites on the

streets and parks in a mobile van in the evenings; and three advocates who obtain entitlement benefits (SSI,VA) for team referred patients. The latter two components are possible through contracts with the District's Department of Human Services. The Disabled American Veterans donated the mobile van to acess those homeless who are non-shelter residents.

The list of resources developed from public and private participation clearly indicates that a partnership has been forged. Two foundations, Eugene and Agnes E. Meyer and Public Welfar, funded the project for $30,000. There are two local health care networks where specialty physicians provide free consultations. George Washington University Hospital does lab work not processed by the D.C. lab. The Red Cross provides the project with hand made ponchos, hats and scarfs. A psychiatrist is provided by Saint Elizabeth's Hospital to work with the teams in the shelter.

A critical component in the Washington project is Christ House a recovery shelter. It provides repite care to those who are too sick to be in shelter and not sick enough to be in a hospital. It is a privately funded service and also houses project offices. The combined resources in this public/ private initiative have allowed HCHP to provide services to 702 persons in 1985 and over 1200 to date in 1986.

Mr. WAXMAN. Ms. Sonde.

STATEMENT OF DIANE SONDE

Ms. SONDE. I want to thank you for asking me here this morning. My name is Diane Sonde, the Director of Project Reachout, which is located at 88th Street and Amsterdam Avenue, in New York City. Project Reachout is sponsored by Goddard Riverside Community Center, a settlement house on the upper West Side, and we are funded with state CSS funds, that is, Community Support Systems, and also private donations.

We are a mobile outreach program that works on the upper West Side of Manhattan, from 59th to 110th Street and all of Central Park. We have three teams and three vans, and we go out usually twice daily, onto the streets and into Central Park. The average workers have varying degrees of experience and expertise, but I should mention to you that we have absolutely no health professionals on staff.

The teams that go out twice a day take bags of sandwiches with them, usually peanut butter and jelly. When we are richer we take balogna and cheese, although I am told that peanut butter and jelly is more nutritious. The sandwich and the fruit juice and sometimes cookies or fruit, depending on what we can afford or what is donated to us, are basically the engagement tools we use to contact people on the street. It is basically our buy-in process. It is all part of trying to establish some kind of trusting relationship with the homeless people who have been out on the street, sometimes weeks, months, and years.

The method of outreach that project reachout uses nobody can really train for specifically. It takes a worker who has a lot of patience, gentle patience I might add, and the ability to go out there day in and day out and see the same people. Sometimes the sandwich is thrown back in our faces. Sometimes we are cussed at, but with good, kind perseverance, we eventually break through, and we can get people to respond to us.

With the engagement process, what we do is assist them with attack their sheer survival out on the streets. We not only give them food, we give them blankets. Hopefully, if we get the grant we have applied for, we are going to be able to give them sleeping bags this winter, gloves, rain ponchos when it is raining out, etcetera. All that leads to the short-range goal of getting them into the office where we can start concentrating on other kinds of services, but the long-range goal is to not only get them into the office but then to get them into a permanent housing situation.

When these homeless people finally come into our office, you might think that that is where things begin to ease up a little. It is not. That is when the real problems begin. We have a little lounge area where they are not forced to talk to anyone or participate in group activities. They can hang out, have coffee, eat more of the same sandwiches, and it is a warm non-threatening atmosphere. That is when we begin to see what kinds of services they need.

Usually when they come in off the street they desperately need a shower. They need to be deloused. They have varying degrees of infestation, which I have learned a lot about lately. We provide cloth-

ing for them, and usually the first step in that process, giving them the shower and giving them new clothing, is something where we can watch some glimmering transformation in them. We can watch them be restored with a sense of dignity that the new clothes and being clean again affords them, and that is where they begin to let us in.

Last year we had a donation of about 700 Misty Harbor raincoats, and we had all these homeless people walking around the upper West Side looking like ex-CIA agents. That really helped their attitude about themselves, because they looked and felt important.

As many of you know, homeless people don't come to us with identification. They don't come to us with a Medicaid card in hand. So when we have to confront their mental health and medical problems, you have no place to turn. In New York City—I am not sure how that differs from the rest of the country—most voluntary hospitals won't see people without a Medicaid card. The municipal hospitals are supposed to see homeless people and provide services to them through the E.R. rooms, but the ER's are very overcrowded.

As Mr. Gallagher explained, the care is not terribly good at the city hospitals, and a homeless person doesn't want to go and sit for hours in these hospitals. Oftentimes it is the worker who has worked with them for months or years out on the street who is able to get them to do anything, but not necessarily sit in a very crowded emergency room.

We try to avoid hospitalization at all costs. Whenever possible we try to work with them on a outpatient basis. That is why we built the shower last year, so we could not only shower people but delouse them. I would like to tell you a story about Herman, who when he finally came into the office had lived in Central Park for over a year. He was terribly overgrown. His beard and his hair made him look like a wild person. His physical appearance was that of an animal who had been let out of a locked cage. He was very agitated. He was very confused. He was disoriented, and he was crawling with lice. His legs were very swollen, and not having health professionals on staff, there was no way we could really tell how serious his condition was, but there was no way we were going to get Herman to go into our vans or anybody else's van to sit in a clinic and wait for hours or to sit in an E.R. in a hospital. We also didn't think he needed any emergency treatment that would warrant hospitalization.

The first step was to attack the lice and get him cleaned up. That whole thing was a process taking over a week. He still looked terribly malnourished and pale, even after we had deloused him several times and cleaned him up. Then we had to start addressing his mental health needs, to try to get him seen by psychiatrists so we could get some kind of quick assessment and then get him the medication he needed that would, hopefully, start stemming the symptoms of his psychosis.

We found after we had him deloused several times, the reason he continued to look so pale is because the lice had been living for a very long time on his blood system, and he had become terribly anemic—with other problems. It took him over a month of sitting

in our lounge area before he could trust us enough so a psychiatrist could sit in the lounge with him. We couldn't take him to a clinic somewhere where he could be seen by a psychiatrist.

There was no way he was going to go, so it had to be a process where a psychiatrist could come to us, sit there and schmooze with him and do their own brief psycho-assessment which would give them enough information so they could prescribe some medication which we would help him manage. In less than a month after he started taking the medication, we witnessed his transformation into a wonderful loving normal human being. Herman had his charming little rituals and everyone in the office learned to love him because of his rituals and because of the way he had of presenting himself.

Without the services that we had on site e.g., the medical team from Health Care for the Homeless and our system where we have psychiatrists come on site between two and three hours a week and volunteer their time we could not have accomplished. We found it impossible to work with this population by having to go to private or public clinics, where they wouldn't see people with or without a Medicaid card, and the traditional system to address mental health needs is you get an appointment on Tuesday at two o'clock in the afternoon. When you are working with somebody who has florid psychotic symptoms, you can't guarantee they will be in that office at two o'clock to see a psychiatrist. You need the services on site when you have the client there.

We assist people once we get them on a medication routine; we assist them in taking their meds, we assist them in getting their entitlements; we assist them in getting the whole shebang in place so we can then try to move them on to some kind of permanent housing situation. And we have been fairly successful in doing that.

One of the best models for us in terms of permanent housing for this type of population has been the SRO-type model, with supportive services and the St. Francis Residence in New York City is a fine example of low-cost housing, with the kind of services this population needs, to keep them off the streets.

Mr. WAXMAN. Thank you very much

[The following brochure was submitted for the record:]

GODDARD-RIVERSIDE COMMUNITY CENTER'S

PROJECT REACHOUT

(212) 595-3066

Services and Advocacy for the Mentally Ill Homeless

What we are...

Project Reachout is a mobile outreach program providing services to the mentally ill homeless on Manhattan's Upper Westside from 59th to 110th Streets—including Central Park. Established in 1979, it is sponsored by Goddard Riverside Community Center and funded largely by State CSS (Community Support Services) funds which are administered by the New York City Department of Mental Health. At present, our project has a total staff capacity of 20 people—13 of whom provide direct outreach services.

How we do it...

Project Reachout outreach teams go out twice daily in vans—initially to gain the trust of mentally ill persons living in the streets. We do this by providing them with food, clothing and blankets. A brown paper bag containing a sandwich, juice and dessert is our "engagement" tool. We also offer showers, medical and psychiatric services, financial assistance, temporary shelter plus a welcoming place to come and sit and have a cup of coffee in our modest office space. Our long range goal is to secure permanent housing, most often in a neighborhood SRO (single room occupancy) hotel or one with supportive services such as the St. Francis Residence. To that end, we help them secure entitlements (welfare or social security disability), we assist with money and medication management and other activities of daily living. When appropriate, we refer them to drop-in centers or day treatment programs in the neighborhood.

Those we've helped...

Project Reachout has provided services to people ranging in age from seventeen to eighty-four, with 35% over 50 years of age. Prior to their life on the street, many had spent years in and out of psychiatric hospitals, most had lived in single room occupancy hotels or other low rent housing. Others had lived with parents or spouses until they died, and became homeless when they were no longer able to maintain their jobs and apartments on their own.

More about us...

Project Reachout provided services to 3,096 different individuals last year. More were males than females. 71% had major psychiatric problems and 15% had both psychiatric and substance abuse problems. Over 24,000 sandwiches were distributed. This past summer we had contact with an alarming number of homeless people—greatly outnumbering those of previous summers. In the month of August alone the team on the street saw a total of 397 individuals—of those 123 were "new" to the outreach team. The Central Park team saw a total of 383 individuals—of those 183 were "new" to the team.

Mr. WAXMAN. Any of you may wish to respond to this. If you were going to advise us on a medical system for people who are homeless, what would you suggest that system be like? Do we need a dual kind of system, a different kind of system, or do we need to help these people get plugged into the existing system that is there?

Ms. SONDE. No, I don't think we can help them plug into the existing system. I think we have to bring the services to them initially, until they are stabilized to a point, but they also need advocates to speak for them. Even if they sit in a hospital emergency room or in a clinic, unless they are able to speak up and clearly enunciate what their symptoms are, what it feels like, where it hurts, they are not going to get any care, to say nothing of quality care. The traditional systems that are in place now do not work for the homeless, both mental health services and medical ones.

Mr. WAXMAN. All three of you are involved in trying to set up a system of linkages between existing programs and new programs as a way to help the helpless. Ms. Wolfe, as I understand it, your project has a great deal of funding from an effort by the Robert Wood Johnson Foundation, Pew Memorial Trust, and that was a four-year funding of—

Ms. WOLFE. $1.4 million.

Mr. WAXMAN. And yours is $25 million?

Ms. WOLFE. No, $25 million nationally.

Mr. WAXMAN. Nationally?

Ms. WOLFE. Yes.

Mr. WAXMAN. $25 million a year over four years?

Ms. WOLFE. Yes. And each city was up to $1.4 million per year.

Mr. WAXMAN. This is private foundation grant money that has gone into trying to develop a system for dealing with the health needs of the homeless. This whole foundation grant has been envisioned for four years and it is in its third year?

Ms. WOLFE. Beginning its third year in January.

Mr. WAXMAN. What is going to happen after the fourth year?

Ms. WOLFE. Each city is supposed to be working, and is working, depending upon how they are structured, what their model is, as to what is the appropriate way. In Nashville they have incorporated into the county health system. It is one clinic. It has been located, but the staff, everybody is going over to the county. That is not going to work in Washington.

In each city, one has to figure out the most appropriate way to do that, whether it be by contract, whether it be by various departments of human service components. They have three commissions now, the mental health, the social services, and the physical health. If those three components get together and fund an agency to do it or fund staff to do it, so that it is working three, and certain things are going to still be the private sector's domain and they are going to be involved.

Our health network would never work without the health network, because the only adult medicine clinics are D.C. General, and many of them have waiting lists of six months to two years.

Mr. WAXMAN. The idea is to let the number of counties and cities that are involved with grant money from this foundation find their

own ways of dealing with the homeless. What role is there for the Federal Government?

Ms. WOLFE. Each of the jurisdictions is struggling with how to financially incorporate this project or these sets of services into their system. It would be helpful to know that there was money to supplement that, because in Washington there is money for drugs and there is money for aides. Those are the two main funding efforts within the city, where there is more discretionary money, and we haven't even begun to talk about homeless families and their problems. Nobody mentioned that.

The notion is that AFDC covers that and their Medicaid. Well, families in crisis and shelter suffer the same disaffiliation and confusion, and therefore don't get appropriate care, so that any Federal intervention that was either programmatic or categorical that would help the cities institutionalize the service or develop the respite care service would be helpful, and certainly any manpower that could be diverted from where it is presently going in some percentage to impact the needs of the cities would be helpful. If we could get psychiatrists to work with Robert Wood Johnson, that would be great.

Mr. WAXMAN. So you are outlining a fairly elaborate network of private and public responsibilities with different government funds and private funds to support it. You have something like this already in effect here in Washington, D.C.?

Ms. WOLFE. Yes.

Mr. WAXMAN. What percentage of the homeless do you think you touch?

Ms. WOLFE. I would assume that we touch somewhere between 75 and 80 percent of the homeless. We try not to duplicate services, and most of those, a lot of those services are directed towards the men because the women shelter system in Washington is smaller, and they have workers, support workers, who are linking people with community-based free clinics or with hospital clinics so I would say that we see somewhere between 75 and 80 percent, and that is the main portion that we don't see is homeless families, and people that are just resistant, that are really resistant.

Mr. WAXMAN. If you see 75 percent, is it fair to say that you are serving the health needs of the homeless in Washington, D.C., at least for 75 percent?

Ms. WOLFE. We have access to that. When you have a mobile outreach, we don't know how many people are really out on the streets, so we can't say in the three weeks or a month that we have been in session how long, so I don't think it is fair to say that we are adequately meeting those needs, and we certainly aren't with the family issue.

Mr. WAXMAN. Ms. Sonde, we hear a lot about whether the homeless are just low-income people without jobs, without a place to live because they can't afford it. We also hear another image, and that is homeless people who are mentally ill. At a previous time, they would have been in a mental institution, but because of the changes in treatment philosophy they were dumped from those institutions, presumably for community care, but the reality is for no care. What is the accurate description of the homeless person?

Ms. SONDE. All of that. We run into a gamut of it. There are certainly those who are left from the deinstitutionalized phase 10 and 20 years ago. People have had histories of long-term hospitalizations and have fallen through these cracks and are on the streets again. But we also have people who have lost their jobs like Mr. Gallagher described, who got depressed, or people who have lost their spouses—that is a larger category—sons or daughters who lived with their parents for long years, and then, when they were in their thirties or forties their parents died off, they lost their jobs, they got confused and disassociated with other family members, and ended up wandering the streets, and with no previous history of mental illness.

We have grandmothers who became estranged from their families and wandered on the streets and became mentally ill while on the street, with having no long history, or any history, of mental illness before.

Mr. WAXMAN. What proportion of the homeless do you think are suffering from chronic mental illness?

Ms. SONDE. The general figure thrown around these days is about 25 percent. I know in the New York City shelter system where single adults are sheltered every night, there are probably 10,000 of those people, and researchers have found that a true 25 percent of them suffer from mental illness severe enough so that they need some kind of supportive housing to live in. They can't just live in housing with no psychiatric support.

Ms. WOLFE. It also changes by city and by region. The far west appears to have less of a chronically mentally ill than the larger urban east.

Mr. WAXMAN. Why is that, do you think?

Ms. WOLFE. Because, well, they call it "greyhounding." They get on a bus and they move right on through. The homeless that stop in Arizona and in Albuquerque are basically homeless because of economic reasons. It could even be health, but it is not necessarily mental health; and mental health people are coming here to Washington to talk to their congressmen; they are coming to talk to their President; they are coming to the V.A. for redress. We have a number of people in Washington who are here because they have come from other jurisdictions to Washington because their veterans' benefits have not worked appropriately, and they stay. They don't go home.

Mr. WAXMAN. Dr. Vicic, do you agree that about 25 percent of the homeless population are chronically mentally ill? Has that been your experience in New York?

Mr. VICIC. In our shelters in New York that figure sounds appropriate, and by chronically mentally ill we mean individuals who have had a history of hospitalization in a psychiatric hospital or a psychiatric division of a general hospital, or the use of psycotropic medications, the prescription of medications specifically needed to address chronic mental health symptoms, so by that definition I would agree with the figure of 25 to 30 percent in New York City.

Mr. WAXMAN. That is a fairly narrow definition. Those are people who have already been through the mental health system or had medications prescribed for them. Wouldn't you have a number of people who would be unable to take care of themselves because

of depression or some other mental illness and because of that wouldn't be in that statistic?

Mr. VICIC. The people who are depressed or the people who suffer what one might call lower grade mental illness may not be as obvious, you are absolutely right, may be uncounted in that figure of 25 to 30 percent. Just in terms of the practice of general internal medicine, we see individuals who are dealing with a physical illness, but who clearly have a psychological burden as well in the setting of that illness, and which the illness either occasions or exacerbates, and I think what I am referring to is your example of the depressed, despairing individual, who also would benefit from mental health care.

Mr. WAXMAN. Mr. Wyden.

Well, we appreciate your testimony. Dr. Vicic, St. Vincent Hospital administers, with Robert Wood Johnson Pew Memorial Trust, the Health Care for the Homeless program. We would like to have for the record any reports or studies that have been produced by this program to date that might assist us in understanding and responding to the health needs of the homeless.

We have to give a great deal of credit to the three of you and to the organizations that you represent, for working to try to meet this need. It is just clear from what you are telling us that the need is greater than those organizations are able to handle on their own. You are asking for help on behalf of the people who are asking you for help. It seems to me that the Federal Government has a very distinct responsibility. Thank you.

Ms. WOLFE. Thank you.

[Testimony resumes on p. 85.]

[The following materials were submitted for the record:]

71-881 - 87 - 2

HEALTH CARE FOR THE HOMELESS PROGRAM

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Health Care for the Homeless Program

The $25 million Health Care for the Homeless Program, begun in 1985 and jointly supported by the Robert Wood Johnson Foundation and the Pew Memorial Trust and co-sponsored by the U.S. Conference of Mayors, is supporting 18 cities with grants of up to $1.4 million each, over a four-year period, for the development of coalitions and networks that will bring health services to homeless people. The Program's intention is to encourage existing agencies and groups within each of the cities to build a network of resources that will deliver hands-on health and social services to homeless people. The Program also seeks to improve access to other available services and public benefits and encourage efforts to address the full range of problems that homeless people face.

The Health Care for the Homeless Program is a national program of The Robert Wood Johnson Foundation and The Pew Memorial Trust co-sponsored by the United States Conference of Mayors and administered by St. Vincent's Hospital.

National Summary

TABLE 1

Summary of Project Activities

Total Clients Seen	42539
Total Visits	118098
Average Visits per Client	2.8

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	94	72	72
APR 1985	563	386	367
MAY 1985	1691	1020	904
JUN 1985	3041	1790	1486
JUL 1985	4507	2669	2078
AUG 1985	5761	3382	2452
SEP 1985	6058	3626	2406
OCT 1985	7845	4561	3034
NOV 1985	5716	3574	2101
DEC 1985	7431	4349	2657
JAN 1986	9197	5316	3371
FEB 1986	8437	4939	2885
MAR 1986	8460	4830	2732
APR 1986	9253	5344	3102
MAY 1986	8846	5093	2764
JUN 1986	8781	4981	2832
JUL 1986	9436	5426	3161
AUG 1986	8014	4689	2464
SEP 1986	4196	2742	1327
Missing or bad dates	771		

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Albuquerque Health Care for the Homeless Project

The Albuquerque project began serving patients on April 8, 1985, in a mobile facility; a 31 foot Airstream trailer was modified to serve as a well equipped clinic. The trailer is moved on a published schedule to locations where the homeless congregate. During July, they opened a permanent clinic in downtown Albuquerque in space donated by St. Martin's Hospitality Center, a day-time drop-in center for street people operated by the Episcopal churches of the area. During one half day per week at the permanent clinic, they serve only women and children, the numbers of whom are growing on the streets. Other persons are seen during this time in the mobile clinic.

Contacts have been made with several agencies in reference to entitlements. They have enlisted the aid of the Social Security Administration, the New Mexico Department of Human Services, the Veterans Administration and others to screen clients for possible entitlements and to assist in making the program known to any homeless they may serve. Flyers and posters are also placed in locations where the homeless congregate, such as the Salvation Army, the Albuquerque Rescue Mission, Good Shepherd Refuge, and others. The most effective outreach toward clients has been the mobile unit, identified as the free clinic for the homeless. It is highly recognizable, much talked about and is the project's most effective advertisement.

An education program for the homeless has been developed and is in operation. Under the general title of, "How to Take Care of Yourself While Living on the Streets," they have presented programs every other week at St. Martin's, the only day-time shelter for the homeless.

St. Joseph Healthcare Corporation is now assisted in the administration of the project by an Advisory Committee appointed by the chairperson of the Albuquerque Emergency Care Alliance. It is made up of representatives of business, federal, state and local governments.

A grant for $25,000 has been awarded to the project by the New Mexico Department of Health and Environment to provide case management services for the chronically mentally ill, along with drop-in services, with the cooperation of a group called Survivors, Inc.

Albuquerque

TABLE 1

Summary of Project Activities

Total Clients Seen	2470
Total Visits	4761
Average Visits per Client	1.9

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	3	3	3
APR 1985	146	133	132
MAY 1985	164	139	121
JUN 1985	175	158	131
JUL 1985	218	187	164
AUG 1985	313	249	210
SEP 1985	203	163	122
OCT 1985	251	190	151
NOV 1985	174	130	98
DEC 1985	250	179	130
JAN 1986	304	209	152
FEB 1986	278	200	129
MAR 1986	357	221	151
APR 1986	399	245	160
MAY 1986	365	224	141
JUN 1986	434	259	168
JUL 1986	404	273	177
AUG 1986	259	176	95
SEP 1986	35	34	25
Missing or bad dates	29		

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Baltimore Health Care for the Homeless

Existing day shelter environments, Christopher Place and My Sister's Place, have been selected as health care delivery sites. These sites house health teams and are equipped to perform medical screening, examinations, and basic treatment using standard protocols for the treatment of conditions.

Clients receive physical examinations whenever specific problems lead them to seek medical care. Treatment regimens are prescribed and followed up by the medical/social work team. Outreach efforts are made in situations where treatment is not continued. When necessary, prescribed medications are stored and distributed from the medical site.

In addition to providing medical treatment on site, the project has arranged for a comprehensive group of other services. These services include: gynecological and cosmetic services, x-ray, optometry, physical therapy, and other services as identified by grant personnel. Increased client accessibility to appropriate services has been developed by pre-arranged agreements with specific service providers to work with grants personnel and clients. Transportation from the health offices is provided, when needed.

The on-site service coordinators and the project director have sought to improve access to necessary benefit programs for the homeless. These programs include Medical Assistance, General Public Assistance, housing assistance, Supplemental Security Income and Veteran's Benefits.

Health Care for the Homeless of Baltimore City (HCHBC) has begun to provide valuable hands-on experience to students including several psychiatric residents and a nurse practitioner candidate.

To augment the project's limited mental health resources, HCHBC utilizes psychiatric residents from Johns Hopkins and is working toward becoming a field placement site for masters of social work candidates, and is planning for more extensive training of all staff on mental health problems. Public funds for additional mental health staff are being sought.

Spokespersons from the following agencies have attended HCHBC staff meetings or training sessions to share information, enhance communication and address issues of concern: Veterans Administration, Social Security, Department of Social Services, Department of Health, Department of Housing, Medical Assistance, Health Education Resource Center (A.I.D.S.), and Baltimore City Police Department.

Baltimore

TABLE 1

Summary of Project Activities

Total Clients Seen	1766
Total Visits	5629
Average Visits per Client	3.2

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	0	0	0
MAY 1985	0	0	0
JUN 1985	48	25	25
JUL 1985	199	123	117
AUG 1985	165	115	78
SEP 1985	278	148	97
OCT 1985	396	227	159
NOV 1985	332	200	128
DEC 1985	365	219	130
JAN 1986	444	277	192
FEB 1986	524	300	201
MAR 1986	343	200	94
APR 1986	362	218	115
MAY 1986	396	181	85
JUN 1986	404	186	80
JUL 1986	484	222	98
AUG 1906	474	202	88
SEP 1986	301	157	60
Missing or bad dates	54		

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Birmingham Health Care for the Homeless Program

One of the major accomplishments of this project has been utilization of a mobile health unit. The van allows staff to provide care on the streets, as well as back-up for all of their eight stationary sites. They can approach the homeless where they congregate. Perhaps their greatest "advertisers" at this point in the project are the homeless people themselves, who spread the word on the street of where and when the van can be found if someone needs care.

Contacts to identify workable referrals have been made at social service agencies, health care providers, etc.

This has resulted in repeated (as many as 4 times) appointment re-scheduling for their patients at disability hearings (usually one missed appointment would result in a closed case), special call-in procedure for obtaining certification for services at the county hospital for their program's patients, and medical laboratory services provided free of charge through Roche Bio-medical labs for extraordinary lab work. Seven Birmingham hospitals have applied to take homeless persons on a rotating in-patient admissions basis for project patients requiring hospitalizations. The agreement states that patients are screened by the project's medical team for admission, to avoid the possibility of patients being turned away by a second-guessing hospital employee.

A shelter providers advisory committee to the project's Board of Directors was established which includes representatives from each major shelter in Birmingham (including the Housing Authority). This group developed a "winter emergency policy". This same group joined forces to become Metro Birmingham Services for the Homeless, a formal umbrella organization committed to identifying gaps and overlaps in services, and improvement of services through securing future funding as a group. The group is currently seeking private foundation funding, Community Development Block Grant (CDBG) monies, and United Way money. A strong alliance between the Mayor's Office, the Housing Authority, this project, United Way and the two major downtown church Coalitions which operate downtown shelters, has been facilitated by this project via the groups brought together to address health care issues.

The Health Care for the Homeless Program is a national program of The Robert Wood Johnson Foundation and The Pew Memorial Trust co-sponsored by the United States Conference of Mayors and administered by St. Vincent's Hospital.

HEALTH CARE
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Boston Health Care for the Homeless

The establishment of three on-site health care teams (Team A and Team B caring for single adults and Team C caring for families) and through these teams the continuing capacity to meet medical and social service needs of homeless individuals at the shelters and day sites and families at the family shelters has been one of the principal achievements of the project.

Other accomplishments include: the establishment of working relationships with and the education of shelter staffs on appropriate uses of new on-site medical clinics; assistance for individuals in establishing eligibility and gaining access to income maintenance programs (nearly 100 individuals approved for state-funded General Relief, 20 persons on file for SSI with 7 approved and 13 pending, and three to four others with applications pending or approved for SSDI and Veterans' Benefits); widespread screening and appropriate intervention in an effort to halt communicable disease (TB screening being carried out by Team A and B and intervention in shigella outbreak at the family shelters); successful channeling of clients requiring more serious medical services to newly established clinics (both pediatric and adult) at participating facilities and for in-patient women, and children with local social service, mental health, educational and other agencies; education and meeting concerns of shelter staffs on detection and control of infectious diseases (e.g., supplying factual information relating to the AIDS, hepatitis, and TB); improvement of relationships between all medical facilities in the City and shelter-referred patients (assurance of follow-up and continuing care has resulted in the provision of better and more readily available care); and influenza vaccination for over 200 adults.

An additional major achievement of the project has been the opening of the Shattuck Shelter Respite Unit in November, 1985.

A major source of financial support for the project has come from the Commonwealth of Massachusetts, Dept. of Public Welfare. In April, 1985, the Department signed a $250,000 contract with the Project for matching funds to enable the Project to address the broad range of health care needs of homeless populations in Boston.

Funding has also been committed by the Commonwealth of Massachusetts through the Department of Mental Health (DMH), which has lent its support by providing the salary of a psychiatrist-consultant.

Additional sites throughout the City are to be considered for delivery of services during the coming year. Soup kitchens, day centers, the developing mental health shelters and other sites are to be examined for potential impact. Feasibility for a mobile clinic or medical van is to be explored.

Boston

TABLE 1

Summary of Project Activities

Total Clients Seen	2482
Total Visits	5938
Average Visits per Client	2.4

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	45	25	25
MAY 1985	18	16	16
JUN 1985	34	27	25
JUL 1985	215	154	143
AUG 1985	522	329	261
SEP 1985	397	266	155
OCT 1985	740	485	331
NOV 1985	380	243	115
DEC 1985	505	322	171
JAN 1986	425	293	178
FEB 1986	333	255	132
MAR 1986	346	244	117
APR 1986	370	274	138
MAY 1986	329	240	116
JUN 1986	277	207	109
JUL 1986	394	314	193
AUG 1986	429	336	201
SEP 1986	103	80	40
Missing or bad dates	76		

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Chicago Health Care for the Homeless Project

The project was designed so that the health teams would be mobile and would visit designated shelters and drop-in centers on at least a weekly basis. This design was chosen to correspond to the decentralized, small scale approach in providing shelter to which Chicago remains committed. On-site services provided by the health teams include: physical assessment; screening; diagnosis; first aid; prescription and some medication distribution; limited primary care (e.g. dressing of wounds); referral/linkage to necessary services; maintenance of treatment plan; follow-up care and monitoring; patient education; assistance in securing benefits and entitlements; social services; outreach; advocacy; and transportation.

The Health Committee of the Mayor's Task Force on the Homeless provides governance and oversight to the project and serves as a forum to address issues and system gaps identified through the project. The Health Committee includes representation from the public and private sectors, as well as groups advocating on behalf of homeless people.

Six sites have been phased into the project's operation.

Outreach staff are a unique feature of Chicago's project. They have proven to be even more crucial than anticipated in serving confused, resistive, and alienated clients. Outreach workers are successful in helping homeless people cope with systems and helping the systems cope with them.

Outreach and social work staff have also been successful in working with local Department of Public Aid and Social Security staff to obtain benefits and entitlements.

Project staff have engaged in advocacy efforts on a systems, as well as individual level. This advocacy has primarily been undertaken through testimony at legislative hearings, television and radio programs, presentations at the National Association of Social Workers Symposium and the American Public Welfare Association meeting, and participation in seminars for Cook County Family Practice Department and the University of Illinois Realities of Medicine Series.

The project has also become a formal placement site for field experience or observation through local Schools of Nursing: Northwestern University, Loyola University, Rush University, and the University of Illinois. Reports from the schools indicate that the students find the project to be among the most enlightening of their field experiences.

Chicago

TABLE 1

Summary of Project Activities

Total Clients Seen	930
Total Visits	721
Average Visits per Client	3.0

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	1	1	1
APR 1985	0	0	0
MAY 1985	0	0	0
JUN 1985	220	132	132
JUL 1985	145	80	60
AUG 1985	273	129	86
SEP 1985	299	169	117
OCT 1985	473	270	211
NOV 1985	430	260	176
DEC 1985	672	368	255
JAN 1986	845	458	323
FEB 1986	752	416	247
MAR 1986	783	435	259
APR 1986	933	486	296
MAY 1986	946	455	263
JUN 1986	656	326	173
JUL 1986	635	306	174
AUG 1986	527	264	134
SEP 1986	16	15	2
Missing or bad dates	115		

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Cleveland Health Care for the Homeless Project

The principal accomplishments of the project to date include:

-Establishment of health care clinics at the two largest emergency shelters on the near east and west side of Cleveland, with the nearby smaller shelters (12 in number) being served by a screening team.

-Formal linkages with entitlement programs including the Social Security Administration, Department of Human Services, Veteran's Administration, Protective Services Consortium and Bureau of Vocational Rehabilitation.

-Establishment of formalized referral link with the county hospital system for purposes of this project.

-Workshops (4 in number) to inform local health care community about the homeless, and the health care problems they face as a result of their lifestyle.

-Establishment of a "Newsletter" to inform and update the local provider community on the progression of the project.

-Implementation of a computerized patient record and data collection system to track patients over consecutive visits, as well as generate monthly demographic reports.

-Implementation of a 24 hour emergency assistance number (using a cellular phone) whereby patients can access health team members day or night for assistance.

-Mental Health Program (funded through state and NIMH) in which mental health specialists develop drop-in centers for the chronically mentally ill homeless.

-Establishment of a volunteer & student program through local volunteer agencies and Universities.

-Formation of a partnership effort between the two levels of government; namely, the City of Cleveland and Cuyahoga County via health service delivery.

-House Bill 515 implemented in Ohio to provide funding for emergency housing shelters for the homeless with the support of the Cleveland Health Care for the Homeless project.

The Health Care for the Homeless Program is a national program of The Robert Wood Johnson Foundation and The Pew Memorial Trust co-sponsored by the United States Conference of Mayors and administered by St. Vincent's Hospital.

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Denver Health Care for the Homeless Program

The project entered into a contractual relationship with Denver Health and Hospitals (DH&H) for the provision of physician, physician assistant and social worker services for the Health Care for the Homeless Program (HCHP). In addition, this contract provides that DH&H provide back-up laboratory, radiology, specialization and hospitalization services as needed without cost to the project.

A walk-in stable site clinic was opened in May, 1985.

At the stable site clinic, named the Stout Street Clinic (SSC) the project provides the following services:

-Primary health care, including diagnosis and treatment of acute and chronic illnesses for adults and children, OB pre and post-natal care and family planning.

-Preventive health care, including immunizations and vaccinations for adults and children.

-Laboratory services, including hematocrit, complete urine analysis, GC smears and cultures. Other needed laboratory services are referred to the appropriate DH&H facility.

-Radiology services are provided for SSC patients at one of the DH&H facilities.

-Pharmacy: In-house pharmaceuticals which cover a broad range of adult, pediatric, family planning and prenatal needs are dispensed at the SSC.

-In-patient care: When needed, SSC patients are hospitalized at Denver General Hospital, a division of DH&H.

-Respite care: Should a homeless patient discharged from Denver General need respite care to ensure adequate recovery post-hospitalization, the patient is placed at the new shelter opened through the cooperative efforts of the Colorado Coalition for the Homeless and the Volunteers of America.

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-Additional medical services: Podiatric care, minor surgery (suturing, incision and drainage, etc.), evaluation and treatment of minor eye problems, inhaled bronchodilator therapy, intervenous therapy, wound care, crutches, ace wraps, slings are all availabe at the SSC.

-Dental care: Through the Dental Clinic at one of the nearby DH&H facilities, they are able to provide dental care for their patients at 25% of cost, which the Health Care Project pays.

-Social services.

-Outreach and transportation services.

-Health education and in-service training.

The establishment of the stable site clinic has proven to be a highly effective strategy for providing health care and social services to the homeless in the community. Placing the clinic in the downtown "neighborhood" of the homeless has made it very accessible to the target population. In addition, the Volunteers of America operate a food line and clothing distribution center in the same building as the clinic, which means a variety of services are provided to homeless persons at the same site.

A contract has also been entered into with the Colorado Division of Mental Health to fund half a FTE mental health therapist position at SSC. The Health Care Project funds the other half. This allows provision of direct mental health services to the large number of chronically and mentally ill patients they serve.

Denver

TABLE 1

Summary of Project Activities

Total Clients Seen	2946
Total Visits	5402
Average Visits per Client	1.8

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	2	2	2
APR 1985	1	1	1
MAY 1985	88	79	79
JUN 1985	171	140	132
JUL 1985	235	176	151
AUG 1985	234	169	134
SEP 1985	192	143	103
OCT 1985	237	189	154
NOV 1985	189	144	127
DEC 1985	131	90	70
JAN 1986	145	88	69
FEB 1986	203	146	109
MAR 1986	540	364	284
APR 1986	549	370	265
MAY 1986	598	394	268
JUN 1986	524	401	283
JUL 1986	529	393	272
AUG 1986	518	399	272
SEP 1986	276	244	150
Missing or bad dates	40		

HEALTH CARE FOR THE HOMELESS PROGRAM

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Detroit Health Care for the Homeless Program

Detroit Health Care for the Homeless Project provides primary health care and casework services at health stations in shelters and soup kitchens which currently serve the homeless. These services are provided by a mobile team consisting of a physician, public health nurse, social worker, part-time outreach worker and driver, who conduct eleven sessions a week at eight different sites. Specialty and hospital services are provided through referrals to Detroit Receiving Hospital/University Health Clinic, where a stationary team of a doctor, nurse and social worker are housed four afternoons a week. Team social workers, beside providing case work services make referrals to a pre-arranged network of substance abuse, mental health and other social service agencies. Social workers and the outreach worker also assist homeless clients in obtaining entitlement services.

The outreach worker makes periodic visits to other shelters, soup kitchens and agencies serving the homeless but not covered by their team, and to make himself known in the community.

The Detroit Health Department is currently making major contributions to the project by including services to the homeless as part of their primary care network.

Wayne State University, through the Department of Community Medicine provides for physician services on a contractual basis.

A large number of children in their client population requires that the team be particularly knowledgeable in pediatrics. A major emphasis in the treatment of children has been making sure that immunizations are up to date, both for school and to prevent the spread of communicable diseases in crowded shelters. To date, strep throats and lice have been the major communicable problems. Their social worker has been helpful in making arrangements to get many of the children into a day care center, so that mothers are free during the day to resolve their problems and seek permanent residences.

A grant from the Michigan Department of Mental Health adds trained psychiatric staff to the team at three of their sites. This allows for more crisis intervention than the social work staff can currently provide and this specially-trained staff is able to reconnect some of the chronically mentally-ill homeless with the existing network of community mental health centers.

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Detroit

TABLE 1

Summary of Project Activities

Total Clients Seen	2354
Total Visits	3997
Average Visits per Client	1.7

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	0	0	0
MAY 1985	3	3	3
JUN 1985	157	130	129
JUL 1985	286	238	207
AUG 1985	253	212	164
SEP 1985	265	223	168
OCT 1985	320	263	201
NOV 1985	279	221	162
DEC 1985	227	196	129
JAN 1986	328	263	187
FEB 1986	331	260	175
MAR 1986	279	223	141
APR 1986	136	124	83
MAY 1986	164	134	77
JUN 1986	175	156	104
JUL 1986	242	204	150
AUG 1986	305	223	145
SEP 1986	223	182	123
Missing or bad dates	24		

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Los Angeles Health Care for the Homeless Program

The objectives of the Los Angeles Health Care for the Homeless Project (LAHCHP) are to: 1) increase primary health care services to the homeless; 2) increase coordination among various medical and social service providers; 3) make services more accessible, and 4) increase first aid, CPR skills, and health awareness among the workers with the homeless. These objectives are implemented through three component programs. The first component is a shelter based primary care center at the Union Rescue Mission on Skid Row managed by the UCLA School of Nursing. The second component is a community based site located in the Venice Beach area at the Venice Family Clinic. The third component is a training and community organization program serving small shelters located outside Skid Row and the Venice Beach area.

In addition to providing direct primary care to homeless clients, the UCLA School of Nursing Health Center and the Venice Family Clinic served as clinical instruction sites for UCLA nursing, medical, and public health students. More than 71 students received supervised training in primary care and the unique needs of the homeless.

In a long range plan to increase primary care services for the homeless, the UCLA School of Nursing Health Center at the Union Rescue Mission took several major steps to develop third party reimbursement mechanisms. These include obtaining approval of the Regents of the University of California for nursing management of the Health Center and a positive preliminary inspection of the site by the state community clinic licensing agency.

Staff are active in their efforts to contact appropriate social and medical service agencies, to develop coordinated referral resources, to identify agencies appropriate for the homeless, and to systematize the referral process. Major meetings have been held between the staff and units of the Los Angeles County Departments of Health Services (DHS) and Mental Health Services regarding tuberculosis control, emergency care, fees for services, discharge planning, mental health care.

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Networking initiated by the project staff among small shelters has successfully increased services provided by other agencies at the shelters. Both primary care components of the project provided outreach health care services to the homeless. Educational leaflets regarding eligibility requirements for the Ability to Pay plan ATP informed homeless clients of their right to this service and increased accessibility to health care.

Los Angeles has been called the "Homeless Capital of the United States," and according to the U.S. Department of Housing and Urban Development, more homeless persons are located in Los Angeles than any other U.S. city.

Several strategies have been developed to cope with the enormous numbers of clients. Triage systems derived from guidelines used in third world countries have been organized. Multiple levels of care have been instituted to allow providers to function at the maximum level that education and regulation allow. As delivery systems funded by the LAHCHP became severely overcrowded, several activities were instituted. Volunteers were recruited to increase the delivery of care and support stressed project staff. The transportation system was called into action to provide access to existing, albeit equally overcrowded, public facilities for overflow clients. Assisted self care has been instituted at project sites for those clients who meet the criteria for this activity.

Los Angeles

TABLE 1

Summary of Project Activities

Total Clients Seen	2059
Total Visits	4652
Average Visits per Client	2.3

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	0	0	0
MAY 1985	0	0	0
JUN 1985	0	0	0
JUL 1985	213	150	150
AUG 1985	229	149	123
SEP 1985	201	125	94
OCT 1985	325	220	171
NOV 1985	218	150	102
DEC 1985	274	187	130
JAN 1986	364	242	170
FEB 1986	266	177	102
MAR 1986	300	200	131
APR 1986	357	234	149
MAY 1986	391	269	173
JUN 1986	481	246	151
JUL 1986	381	262	167
AUG 1986	361	245	134
SEP 1986	291	213	112
Missing or bad dates	0		

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Milwaukee Health Care for the Homeless

The goal of the Milwaukee Health Care for the Homeless Program has been to establish four primary health care clinics in areas frequented by the homeless. These clinics address both the health problems and the social service problems of the homeless.

The model for Milwaukee's program called for a sub-contract model rather than a direct services system. Before services could be delivered they negotiated six sub-contracts; three contracts with medical providers and three contracts with social service agencies.

Their first clinic opened at St. Benefict's Mealsite. Their second clinic opened at the Guest House. The third clinic to open was at the Salvation Army Emergency Lodge, and the last clinic to begin services was at the Family Crisis Center.

Milwaukee's program has allowed a better utilization of present programs and services. Referrals from our program to others are recognized and there are fewer "red - tape" problems. This communication has led to the development of new programs. Their interaction with other agencies has shown the short-falls of the system and they are working with these agencies to create programs which will fill the holes in the system.

Milwaukee's project has made many new links for the homeless in obtaining eyeglasses, dental care, housing, and benefits. Their most important advances have come in working with local Community Support Programs.

Of the four Community Support Programs in Milwaukee, they are presently working with three.

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Milwaukee

TABLE 1

Summary of Project Activities

Total Clients Seen	1035
Total Visits	5042
Average Visits per Client	4.9

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	1	1	1
APR 1985	0	0	0
MAY 1985	0	0	0
JUN 1985	36	27	27
JUL 1985	146	86	72
AUG 1985	309	132	97
SEP 1985	326	109	61
OCT 1985	445	161	87
NOV 1985	303	113	34
DEC 1985	270	118	34
JAN 1986	334	134	55
FEB 1986	467	154	64
MAR 1986	455	154	61
APR 1986	347	164	73
MAY 1986	344	179	82
JUN 1986	320	159	72
JUL 1986	467	213	111
AUG 1986	300	151	49
SEP 1986	130	77	45
Missing or bad dates	42		

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Nashville Project Health Care for the Homeless Program

The Nashville project has established a freestanding clinic providing Nashville's homeless with primary health care, social services and mental health services.

The Downtown Clinic opened its doors to Nashville's homeless on June 3, 1985.

The medical service is directed by a full-time physician.

A social service unit conducts an intake interview with each patient, and provides on-going social case management services for selected clients.

The Downtown Clinic became payee for five patients' disability or social security checks in 1985.

The Clinic specializes in locating affordable housing for clients, and manages the cases of homeless juveniles who come into the Downtown Clinic system. Access to local entitlements is provided by a Metropolitan Social Services Department worker on site half time.

Specialized case management services are provided for the homeless mentally ill by two mental health specialists, one funded through a contract with the Tennessee Department of Mental Health and Mental Retardation, the other deployed at the Downtown Clinic by the Meharry Community Mental Health Center.

The development of Matthew Walker Health Center, a federally funded community health center, as a referral resource for free x-rays and diagnostic laboratory work has been of particular importance to the project. Metropolitan General Hospital, Hubbard Hospital or Meharry Medical College and the clinics of the Metropolitan Health Department have been major referral resources for medical needs. The infirmary of the Nashville Union Rescue Mission has been available to patients of the Downtown Clinic who require bed rest.

Efforts at outreach have been undertaken, by maintaining a presence at two soup kitchens on a weekly basis, by occassional educational presentations at a day shelter, and by assigning mental health workers to search the streets for individuals in need of their services.

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Nashville

TABLE 1

Summary of Project Activities

Total Clients Seen	3158
Total Visits	14036
Average Visits per Client	4.4

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	0	0	0
MAY 1985	8	4	4
JUN 1985	535	194	192
JUL 1985	719	317	233
AUG 1985	731	329	204
SEP 1985	691	317	170
OCT 1985	798	377	201
NOV 1985	590	329	139
DEC 1985	669	321	131
JAN 1986	943	410	173
FEB 1986	838	401	203
MAR 1986	1004	431	192
APR 1986	1097	459	197
MAY 1986	1001	461	215
JUN 1986	1100	497	242
JUL 1986	1302	531	266
AUG 1986	1055	478	201
SEP 1986	851	437	176
Missing or bad dates	104		

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The New York City Health Care for the Homeless Program

The New York City Health Care for the Homeless Program is administered by the United Hospital Fund of New York on behalf of a broad network of public and voluntary agencies concerned with the homeless. The New York City Project is specifically designed to provide health and social services at soup kitchens, non-public shelters, and social service agencies serving the homeless. No services are provided at city run shelters.

All services are provided under contract by three health care providers: Betances Health Unit, Inc. in Manhattan; Bedford Stuyvesant Family Health Center in Brooklyn; and Montefiore Medical Center in the Bronx. The New York City Project is designed to serve the homeless in three different boroughs.

The New York City Health Care for the Homeless Program has been approved by the State of New York as a demonstration project for alternate documentation for Medicaid. This allows those persons who are truly homeless to receive Medicaid without all of the documents regularly required. Although the person does not receive a Medicaid card, a number is issued, thereby allowing the person to be treated at a clinic and to obtain medication.

Social workers are getting the maximum number of homeless clients on Medicaid. This is being accomplished through regular Medicaid, where possible, and through Alternate Documentation for Medicaid.

Montefiore Medical Center has designed its program so that many of the costs of the program are reimbursed through a special "Home Care Rate" under Medicaid.

For all providers, the eventual aim is to get Certificate of Need approval for their delivery sites as "diagnostic and treatment facilities" within the State's definition of "institutional providers" (New York State Article 28). If the sites can obtain "Article 28 Status" many costs of the program could eventually be covered by Medicaid.

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New York City

TABLE 1

Summary of Project Activities

Total Clients Seen	1887
Total Visits	4945
Average Visits per Client	2.6

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	2	2	2
APR 1985	1	1	1
MAY 1985	6	5	5
JUN 1985	67	54	50
JUL 1985	136	93	78
AUG 1985	155	71	46
SEP 1985	126	70	52
OCT 1985	210	106	66
NOV 1985	147	95	61
DEC 1985	429	225	162
JAN 1986	488	257	190
FEB 1986	478	250	161
MAR 1986	496	331	203
APR 1986	515	339	213
MAY 1986	355	236	122
JUN 1986	466	281	169
JUL 1986	356	254	166
AUG 1986	261	145	69
SEP 1986	219	142	62
Missing or bad dates	32		

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Philadelphia Health Care for the Homeless Project

Philadelphia's Health Care for the Homeless Project utilizes teams of nurses and social workers to contact clients at sites to provide care and connect clients with a range of additional health and social services in the community. Philadelphia's Project has two teams fully operational. The teams consist of one nurse, one nurse-practitioner and one case manager. The teams have provided health and social services in ten shelters and soup kitchens in Philadelphia.

While the primary accomplishment of the Project has been the delivery of health and social services to homeless clients, the following additional achievements can also be cited:

- -The major source of referral for clients seen by the Project is to Philadelphia's Health Center #2 where additional diagnostic work and treatment take place.

- -Some changes in benefits access have also been accomplished. A lidison with the Social Security Administration has been established to provide immediate answers concerning eligibility questions. On-site visits by Social Security officials to determine clients' eligibility for benefits have been authorized. Mailing addresses for clients to use for eligibility determination of benefits have been found.

- -In addition, other service providers (e.g., College of Podiatry, College of Optometry) have developed special referral and/or treatment procedures aimed at minimizing problems of access for clients.

- -A major accomplishment of Philadelphia's Health Care for the Homeless Project has been the development and implementation of a Management Information System (MIS) funded by the Pennsylvania Department of Public Welfare to support the activities of the Project.

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Philadelphia

TABLE 1

Summary of Project Activities

Total Clients Seen	1825
Total Visits	4921
Average Visits per Client	2.7

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	13	13	13
MAY 1985	193	119	112
JUN 1985	258	159	121
JUL 1985	300	200	143
AUG 1985	276	189	125
SEP 1985	272	199	132
OCT 1985	313	192	112
NOV 1985	188	137	87
DEC 1985	222	145	96
JAN 1986	311	198	118
FEB 1986	248	152	71
MAR 1986	245	145	75
APR 1986	277	157	80
MAY 1986	365	186	102
JUN 1986	434	234	131
JUL 1986	379	224	112
AUG 1986	344	214	111
SEP 1986	266	163	81
Missing or bad dates	17		

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Phoenix Health Care for the Homeless

The Phoenix Health Care for the Homeless Project has assisted in efforts to deal with the homeless issue by providing community oriented primary health care services to the Homeless population in the City of Phoenix. Assistance has been given in the development of a continuous, comprehensive, accessible, and coordinated health services system for the Homeless population. There are three primary providers involved; Maricopa County Department of Health Services (MCDHS) (provides medical services); Advocates for the Disabled (provides disability evaluation services); and Phoenix South Community Mental Health Center (provides outreach services). The Health Care for the Homeless Clinic and other services for the homeless operate out of a Homeless Shelter complex. This was designed to facilitate meeting the basic needs of shelter, health care, counseling and other support services.

The Maricopa County Department of Health Services (MCDHS), Division of Ambulatory Care, has included the homeless clinic in the overall Ambulatory Care operational planning process. This move has resulted in the development of goals and objectives specifically for the Health Care for the Homeless Clinic.

Advocates for the Disabled assisted 180 homeless individuals in obtaining services to meet basic needs, documenting claims for disability entitlements, and resettling successful claimants in the community. Of 78 cases closed, 57 percent had successful outcomes; primarily, approval for Social Security Disability Insurance Benefits, Supplemental Security Income, or concurrent benefits. Five clients reentered the work force. The balance of the closures represent clients who did not complete the claims process and whose cases were closed for loss of contact, death, movement from the area, or withdrawal of the claim.

With the purchase of two vehicles, the Outreach Team has become mobile, greatly improving the ability of the team to contact homeless in outlying areas of the county. Weekly, the Outreach Team is scheduled to visit enclaves in the community (i.e., river bottom, desert areas) where many homeless temporarily reside.

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Phoenix

TABLE 1

Summary of Project Activities

Total Clients Seen	3250
Total Visits	9853
Average Visits per Client	3.0

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	2	2	2
APR 1985	135	83	83
MAY 1985	571	304	267
JUN 1985	494	283	193
JUL 1985	628	297	187
AUG 1985	578	320	189
SEP 1985	573	323	155
OCT 1985	612	361	197
NOV 1985	530	344	173
DEC 1985	683	408	215
JAN 1986	694	430	219
FEB 1986	560	385	195
MAR 1986	71	56	8
APR 1986	644	397	257
MAY 1986	621	367	173
JUN 1986	585	365	176
JUL 1986	611	381	191
AUG 1986	623	389	180
SEP 1986	624	403	188
Missing or bad dates	14		

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San Antonio Health Care for the Homeless Program

The principal objectives of the project are to provide health care services for the homeless at two shelter sites and to build a medical and social service network in the local community that can help move homeless people out of their state of being homeless. The ultimate objective of the plan is to place the homeless in jobs and homes, allowing them to be independent from the services being offered by the shelters and by the Health Care for the Homeless Program (HCH).

A four person HCH team has been placed in both the Salvation Army Shelter and the SAMM Shelter. Each team includes a Family Nurse Practitioner, a Medical Assistant, a Social Worker with a master's level accreditation, and a Team Coordinator/Secretary.

The secondary level of medical care is provided by the Bexar County Hospital System if the client is a resident of the county and by contractual agreements with two Urban Health Initiative Clinics with close proximity to the two shelters if the client is not a resident of the county. Bexar County MHMR provides help in addressing the needs of the mentally ill and the Metropolitan Health District assists in detection and control of communicable diseases, primarily tuberculosis, and venereal diseases. Emergency Medical Services (EMS) takes emergency cases, on a rotating basis, to the county hospital, one of three private hospitals in the downtown area, or Brooke Army Medical Center. The San Antonio State Chest Hospital helps with severe cases of tuberculosis.

The social service case management system and network includes all agencies and organizations in the community involved with employment, substance abuse, entitlements, housing, clothing, and additional counseling as required. Most of these agencies and organizations, whether public or private, are members of the San Antonio Health Care for the Homeless Coalition.

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San Antonio

TABLE 1

Summary of Project Activities

Total Clients Seen	1938
Total Visits	5701
Average Visits per Client	2.9

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	0	0	0
MAY 1985	0	0	0
JUN 1985	0	0	0
JUL 1985	0	0	0
AUG 1985	196	109	109
SEP 1985	164	112	87
OCT 1985	180	126	100
NOV 1985	201	131	101
DEC 1985	574	284	236
JAN 1986	621	314	230
FEB 1986	586	301	194
MAR 1986	471	226	127
APR 1986	325	156	105
MAY 1986	460	225	153
JUN 1986	511	220	141
JUL 1986	601	265	168
AUG 1986	654	261	145
SEP 1986	153	102	42
Missing or bad dates	4		

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HEALTH CARE FOR THE HOMELESS PROGRAM

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San Francisco Health Care for the Homeless Program

The Program provides direct health care and social services to residents of four shelters and three hotels for homeless people, as well as visitors to a center for homeless and runaway youth. The services to homeless adults in the shelters and hotels are provided by two mobile teams consisting of a nurse practitioner, medical social worker and mental health worker, with physician and psychiatrist back-up. The services to homeless youth are provided at the Larkin Street Youth Center medical clinic, which is staffed by a physician and a nurse practitioner who specialize in adolescent medicine.

The Program has already established an administrative base within the Department of Public Health. The Project Director and Medical Director of the Program are respectively the Director and Medical Director of the Medically Indigent Adult (MIA) Program which oversees the Department's services to indigent residents. Administration of the subcontract for the mental health component of the Program has been integrated into a broader network of mental health services for the homeless recently developed by the Department's Mental Health Division. The Program's social work staff receive support and supervision through the Medical Social Services Department of San Francisco General Hospital. San Francisco General Hospital and the Mental Health Division have agreed to provide laboratory, x-ray and pharmacy services to people referred from the Program.

The Department's AIDS Activity Office provided funding for a program developed in conjunction with the Mayor's Homeless Task Force, the Department of Social Services and Program staff to house and support people with AIDS or ARC who have concurrent substance abuse or serious mental health problems.

The University of San Francisco School of Nursing, which has had student nurses in the shelters for four years, has integrated its student training into the Program. The San Francisco State University Graduate School of Social Work has had graduate social work students serving their internships with the program since its inception. Medical students from the University of California, San Francisco and Stanford University have worked as volunteers with the Program.

The Health Care for the Homeless Program is a national program of The Robert Wood Johnson Foundation and The Pew Memorial Trust co-sponsored by the United States Conference of Mayors and administered by St. Vincent's Hospital.

San Francisco

TABLE 1

Summary of Project Activities

Total Clients Seen	1655
Total Visits	2940
Average Visits per Client	1.8

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	0	0	0
APR 1985	0	0	0
MAY 1985	0	0	0
JUN 1985	1	1	1
JUL 1985	0	0	0
AUG 1985	0	0	0
SEP 1985	0	0	0
OCT 1985	12	12	12
NOV 1985	13	12	12
DEC 1985	107	100	100
JAN 1986	358	276	262
FEB 1986	335	239	197
MAR 1986	336	207	162
APR 1986	398	259	216
MAY 1986	315	227	188
JUN 1986	330	204	162
JUL 1986	457	276	211
AUG 1986	214	132	94
SEP 1986	40	38	25
Missing or bad dates	24		

HEALTH CARE FOR THE HOMELESS PROGRAM

St. Vincent's Hospital
Dept. of Community Medicine
153 W. 11th Street
New York, New York 10011

(212) 790-7065

Philip W. Brickner, M.D.
Director

Stephen L. Wobido, C.S.W.
Deputy Director

Seattle Project of the Health Care for the Homeless Program

In Seattle three geographically-based teams provide health and social services.

- The North Team consists of a nurse practitioner, mental health counselor, and social worker who provide services to women and children, and at one site single men, housed in northend shelters. Services include onsite casefinding, triage and medical treatment, in addition to referral and follow-up for other needed services.
- The South Team staff includes a community health nurse and mental health counselor who provide health care assessments and case management services to homeless families who reside in the Seattle Emergency Housing sites. Referrals are made to the neighborhood clinics located in the same housing projects as the Seattle Emergency Housing sites.
- The Downtown Team is staffed to serve the large and varied downtown homeless population. Community health nurses, mental health workers, an alcoholism counselor, and nurse practitioner work with homeless men, women and youth in various downtown shelters programs. Services vary slightly according to the specific site within which they are organized, but include on-site health screening, triage, referral and follow-up. At some sites primary health care is provided as well as counseling and crisis intervention.
- The Minority Access Team addresses the special needs of the minority homeless populations of Seattle.

Services are offered at 14 shelter sites.

Some of the accomplishments of the service teams follow:

- Project staff has been able to establish standing appointments for first-time psychiatric evaluations in conjunction with Pioneer Square Clinic. The former six-week waiting time is now down to one week.
- Three clinic outstations have been established at downtown shelters housing women and children -- Lutheran Compass Center, YWCA and the new Broadview Emergency Shelter.
- The 45th Street Clinic, lead health agency of the North Team, has assembled a strong multi-racial, bilingual team with the ability to serve a wide range of clients.

The Health Care for the Homeless Program is a national program of The Robert Wood Johnson Foundation and The Pew Memorial Trust co-sponsored by the United States Conference of Mayors and administered by St. Vincent's Hospital.

Seattle

TABLE 1

Summary of Project Activities

Total Clients Seen	4318
Total Visits	12783
Average Visits per Client	3.0

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	1	1	1
APR 1985	6	5	5
MAY 1985	126	99	96
JUN 1985	286	194	166
JUL 1985	396	220	164
AUG 1985	637	370	293
SEP 1985	820	442	304
OCT 1985	1039	519	314
NOV 1985	614	377	213
DEC 1985	857	441	231
JAN 1986	913	537	316
FEB 1986	933	533	317
MAR 1986	1059	611	348
APR 1986	1190	651	342
MAY 1986	1126	642	312
JUN 1986	957	566	317
JUL 1986	1053	602	325
AUG 1986	707	447	235
SEP 1986	1	1	0
Missing or bad dates	62		

HEALTH CARE
FOR THE HOMELESS
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Washington, D.C. Health Care for the Homeless Project

Four health stations have been located in shelters. They are at Pierce, for men; House of Ruth, for women; Community for Creative Non-Violence (CCNV), men & women; and Central Union Mission. The Central Union Mission (CUM) site serves the male resident population but has the capacity to serve women referred from any of the women's day programs.

The core of the health delivery system is the Project staff. Key to the success of the project are Columbia Road physicians who provide the two teams with leadership, supervision and support. Each team is headed by a nurse practitioner or a physician's assistant who coordinates service with the clinical social worker and the medical/clerical assistant. The team is rounded out by the staff assistant who functions as a van driver and patient advocate.

Soon after the first two health stations were in operation, a problem developed in scheduling HCHP patients for full physicals at the community based clinics. The private community based clinics must serve their own patient load and often that did not provide sufficient slots for HCHP referred patients. A backlog began to occur which frustrated the teams efforts.

With the completion of a respite care shelter, it became desirable to open a fifth health station at the site of Christ House. A physician performs full physicals during a half day clinic duty there.

The project has referred patients needing consults to physicians who are part of two voluntary health networks. Patients are usually seen at the doctors office and are transported by HCHP. This has been invaluable for many of DCGH medical clinics have lengthy (months) waiting lists.

Two psychiatric residents from St. Elizabeths Hospital provide psychiatric support to the mobile health teams. Their presence has been invaluable in stabilizing patients and preparing them to link with the community mental health system.

The project has received funding from Department of Human Services to implement an entitlement assistance component. Three staff work with patients referred from the mobile teams to properly develop benefit applications. Special emphasis is made to obtain disability due to health problems. Psychiatric disability is also obtained or reinstated depending upon the patient's situation.

The Commission of Public Health is developing plans to fund a project that will take health care to the streets, parks and bridges. A HCHP staffed van will follow the evening food distribution trucks and attempt to provide minor treatment and screenings. Follow-up for full physicals and all the other services HCHP patients receive will be availabe to outreach patients.

Washington

TABLE 1

Summary of Project Activities

Total Clients Seen	1279
Total Visits	6374
Average Visits per Client	5.0

Number of Visits, Clients, and New Clients by Month

	Number of Visits	Number of Clients	Number of New Clients
MAR 1985	27	13	13
APR 1985	81	31	22
MAY 1985	260	96	83
JUN 1985	335	113	68
JUL 1985	348	133	76
AUG 1985	419	174	98
SEP 1985	305	139	67
OCT 1985	450	173	110
NOV 1985	371	141	55
DEC 1985	372	161	80
JAN 1986	571	219	123
FEB 1986	483	199	70
MAR 1986	498	212	91
APR 1986	502	202	71
MAY 1986	380	179	61
JUN 1986	356	186	78
JUL 1986	251	115	45
AUG 1986	247	125	43
SEP 1986	50	39	10
Missing or bad dates	68		

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Health Care of Homeless People

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Health Issues in the Care of the Homeless

Philip W. Brickner

> For every hour and every moment thousands of men leave life on this earth, and their souls appear before God. And how many of them depart in solitude, unknown, sad, dejected, that no one mourns for them or even knows whether they have lived or not.[1]

The medical disorders of the homeless are all the ills to which flesh is heir, magnified by disordered living conditions, exposure to extremes of heat and cold, lack of protection from rain and snow, bizarre sleeping accommodations, and overcrowding in shelters. These factors are exacerbated by stress, psychiatric disorders, and sociopathic behavior patterns.

A caveat: shelter and food are the prime needs of homeless people; health matters, important as they are, generally follow next.

Why are we concerned about the health of homeless people? A straightforward desire to help others in trouble is part of the answer; a wish to make our society as humane as we can. Public health issues arise as well; for example, the persistence of pulmonary tuberculosis in this group means a pool of infection that can spread outward.[2-4]

The information base about health problems of the homeless is rudimentary. During our attempts to learn about earlier work in the field, we have discovered a virtual library of sociological texts[5,6] based

upon the romance of skid row. Studies of derelicts have produced many a Ph.D. thesis. In all this work, however, there is rarely a comment about health or disease. The same vacuum exists in the 957 pages of the 1982 *Congressional Hearing on Homelessness in America*.[7]

DEFINING THE HOMELESS

The number of homeless people in our country is not known.[8,9] Without doubt, from the time our species has existed, individuals handicapped by physical or emotional disorders, addiction, societal prejudice and/or aberrant behavior have tended to slide to the bottom of the social scale. Since cities have existed, such people have congregated in the least expensive, most deteriorated areas, where conduct and appearance that would not be tolerated elsewhere are accepted. These people are unlikely to be recorded in any census. They are not domiciled, tend to avoid answering questions, and are often afraid, suspicious, or angry.

The present surge of interest in the homeless is laudable by any measure, but the size of the problem may not in fact be news. In New York City, recent estimates are that the homeless may number as many as 36,000.[10-12] This figure, although of uncertain validity,[13] compares interestingly with the 1964 survey data prepared by George Nash of Columbia University:[5] Manhattan had at least 30,000 homeless men not on the Bowery; a Bowery count added 7,611 more.

The concern about homeless persons is worldwide, as studies from Sweden,[14] Canada,[15] and England[16] indicate. A case in point is the Soviet Union, where "winos" are commonplace—dotting the pavements, staggering through crowds, accosting passersby.[17]

Random distribution of any large population will leave a proportion at the lowest end. Is the figure in the United States 1 percent? If so, there are about 2.4 million homeless. Is it 0.5 percent? Then the homeless number about 1.2 million. Federal government estimates that there are about a quarter of a million homeless persons in the country[18] are probably an understatement.

Our definition of the homeless in this discussion includes:

- skid row people;
- patients discharged from mental hospitals;
- the new homeless, purportedly without shelter because they are economic casualties;
- homeless youth;
- homeless women.

We must add those who are living isolated lives in rooming houses and single-room-occupancy (SRO) hotels. In those inner city areas where the phenomenon of gentrification is taking place, SRO residents are at risk of homelessness. Furthermore, the similarities of personal conduct and illness between truly homeless individuals and those in marginal housing are striking.[19]

SKID ROW

Skid row has come to mean the sections of a city where the down-and-out cluster.[20] The term derives from Skid Road in Seattle, where logging teams pulled their loads to a mill.[21] "This street became the locus for cheap bars, cheap entertainment and cheap lodgings."[12] *Skid row*, or *skid road*, as a term, has assumed highly attractive metaphorical qualities. It stands for a downhill course of life that is out of control.

Bogue estimated in 1963[22] that at least fifty cities in America had identifiable skid rows. This figure is probably acceptable today,[23,24] although skid row itself has changed over the years. As Hopper and Baxter point out:

> . . . the new skid row has as its most obvious feature the distinction that it is no longer confined to well-demarcated "tenderloin" areas of large cities. In most places, the homeless have ceased to observe the old strict geographical bounds. In New York City, the streets and subways, doorways and alleyways, public parks and transportation depots are home for thousands of our citizens each night.[10]

Rough estimates suggest that about one-fifth of homeless people are skid row persons,[5] largely men who have sunk to the bottom of the social scale: chronic alcoholics, derelicts, chronic psychotics. Generalizations of this sort are, of course, highly simplistic and suspect; demographics shift, neighborhoods change,[6] definitions are inaccurate, and overlapping occurs.

PATIENTS DISCHARGED FROM MENTAL HOSPITALS

Schizophrenia and other major psychiatric disorders are significantly overrepresented among the homeless.[15,25-30] Where do these people come from?

By the mid-twentieth century, mental hospitals had become recognized as institutions inherently custodial in nature. Attempts to cure patients of psychiatric disease were ineffective, and costs of care were high. These hospitals, and the government policies that sustained them, were perceived increasingly as mechanisms for social control without due process. A consensus grew in favor of a new, nonhospital mode of treatment that would require a spirit of humaneness, public favor, and financial feasibility. The harsh, custodial spirit was to be changed into one of kindness and warmth.[31]

In about 1955,[30] the community psychiatry movement, in association with public advocates and civil libertarians, initiated a process that led to the discharge into the community of patients from state mental hospitals. State governments, perceiving the potential for cost decreases, were willing partners in this effort. The numbers of state psychiatric hospital patients in the United States, at a peak of 558,992 in 1955,[32] had fallen to 248,518 by 1973,[33] had reached a figure of about 146,000 in 1979,[34] and is thought to be at a level of 132,000 in 1984.[35] Community care was presumed preferable to incarceration. Through this process the accepted public policy goals[31] for the mentally ill were to be retained:

- protection of dependent people as a humanitarian act;
- social control of deviant individuals;
- seeking cure of disease at an acceptable dollar cost.

The design for services, as alternatives to state hospitals, was to include care in community mental health centers, outpatient departments, family care homes, halfway houses, psychiatric beds in community hospitals for crises, after-care provided by psychiatric social workers and community-oriented psychiatrists, and sheltered workshops.

The discovery of new medications was a potent element in this design. Psychotropic drugs such as chlorpromazine (Thorazine) were felt to offer the ideal of therapy: humane treatment instead of custody, social control, and low cost. These drugs "promoted psychiatrists to physicians in the eyes of some of their colleagues, and the insane to the status of patients in the eyes of many members of the public."[36]

It is evident to any observer of the passing scene that this attractive theoretical plan has failed to a significant degree. Numerous, although uncounted, psychotic people are suffering on the streets and in shelters without adequate mental health services. A careful analysis in a major New York City shelter for the homeless[29] revealed that one-third of the residents present for two months or more had a prior his-

tory of state hospitalization. Others were psychiatrically ill, but without a record. The process of state hospital discharge, which started more than twenty years ago, continues. (See Table 1.1.)

Restrictive admission policies deny many chronic psychotic patients the opportunity to return to state institutions on those unfortunate occasions when placement appears to be the best option. The road back to the mental hospital is nearly closed.[31]

Why has the community psychiatry movement failed these people? Segal and Aviram, in an admirable summary,[31] point out that a major reason is community opposition to placement. Fear of the mentally ill, sense of threat about behavior and conduct, and anxiety about loss of local property values are present. Exclusionary laws to inhibit sheltered community housing have been created. Informal mechanisms are developed for stalling, including "impossible" fire permit regulations. As a result, former mental patients, unwelcome and impoverished, drift into skid row and ghetto areas, the streets and shelters.

States have issued regulations to deal with the consequences of deinstitutionalization. However, funds have not been made available to fulfill these regulations, and motivation may be lacking as well. The results are present for all to see.

Irony abounds. Manhattan State Hospital on Ward's Island in New York City discharged many of its chronic patients to the streets during

Table 1.1. New York City Shelter Survey—Most Recent Year of Discharge from Psychiatric Institution

Year(s)	*Number*	*Percentage*
1981	13	28.3
1980	9	19.6
1979	6	13.0
1978	1	2.2
1977	3	6.5
1972–1976	9	19.5
1961–1971	5	10.9
Totals	46	100.0

(From Crystal S. Chronic and situational dependency: long term residents in a shelter for men. New York: NYC Human Resources Administration, May 1982, p. 23. Reprinted with permission.)

the past twenty years. It became an underutilized facility with empty buildings. At the same time, the government of New York City lacked shelter space for the growing number of homeless persons. Logic prevailed, and the state leased the empty space to the city for a nominal sum. Now this city shelter, previously part of the state mental hospital system, houses in substantial number the same people who were previously wards of the State.[37]

THE NEW HOMELESS

The recent prolonged recession left unemployed many people who previously held borderline jobs. A residuum is on the streets and makes up a significant although uncertain number of the homeless.[30,38] An aggravating factor is the chronic problem of high unemployment among black youths and other minority-group members.[13]

Estimates of numbers are weak and their application questionable on a national basis. The most dependable is a thorough analysis carried out at the Keener Shelter in New York City by the Human Resources Administration. Thirty-eight percent of the men who had been at the shelter for two or more months cited joblessness as their reason.

> It is important to note that being "unproductive" members of society is a new status for a large proportion of the homeless. Many men and women speak of past employment as clerks, dishwashers, factory workers, domestics, and various other unskilled occupations . . .[37]

Alienation from family was a significant element as well, indicated as a factor by 28 percent in the Keener study. (See Table 1.2.)

HOMELESS YOUTH

Children and adolescents on the street are often ignored when considering the problem of homelessness. They should be included; and while their health status is probably better than that of older homeless men and women, they are subject to trauma, venereal disease, and psychiatric illness. According to a congressional study released in 1982, there were between 250,000 and 500,000 homeless youths in the United States.[7] Analyses from Boston, Albany, Binghamton, and Buffalo provide support for this rough figure.[39,40] Many of these young people are

Table 1.2. Reason for Admission to Keener

Reason	*Number*	*Percentage*
Lost job	48	38.1
Can't stay with family or friend	36	28.6
Want to get off the street	29	23.0
Eviction	23	18.3
Drinking	11	8.7
Hospital discharge	4	3.2
Mugged	4	3.2
Other	45	35.9

Multiple responses were tabulated so percentages total more than 100.

(Adapted from Crystal S. Chronic and situational dependency: long term residents in a shelter for men. New York: NYC Human Resources Administration, May 1982, p. 9. Cited with permission.)

alienated from their families. A considerable proportion were discharged from foster care by superannuation, with no skills and no place to live.[41]

HOMELESS WOMEN

"Bag lady" is an epithet of recent vintage. Until perhaps the mid 1970s, comments on or studies of the homeless population were concerned with men only. We note now a considerable but uncertain number of women in shelters or other locations. Best estimates are that women make up 20 percent or more of the total.[13,26,27,42] Explanations for this development include the deinstitutionalization process; the fact that older women compete poorly in the job market; the reality that they earned salaries lower than men when employed and therefore had less opportunity to establish financial security; the loss of inexpensive housing to urban renewal; singleness or alienation from family; and flight from an abusive spouse.

Homeless women suffer the ills of their male counterparts, as well as conditions specific to the female sex. They are more likely to develop peripheral vascular disease and its consequences because of a sex-borne tendency to varicose veins and venous insufficiency. Bag ladies on the street with massively swollen legs wrapped in rags are a well-known

sight. They are more easily victimized and subject to assault. There appears to be a high index of severe emotional disorders in these women. This finding may be factitious, however, because the homeless lifestyle in itself produces emotional reactions that are bizarre.

> To be hungry, cold, deprived of sleep, and socially isolated for even a short period can be mentally and physically wearing. The symptoms of those with mental disabilities are easily exacerbated on the streets. . . . For those who were spared mental illness before they became homeless, the daily stresses of a marginal survival can be highly disorienting . . .[37]

SINGLE-ROOM-OCCUPANCY (SRO) RESIDENTS

Conversion of rental housing to condominiums and cooperatives, known as *gentrification,*[38] has become a compelling financial attraction to real estate interests.[43] As gentrification moves forward, people living in SROs or other inexpensive housing on marginal incomes are the first to be displaced. The street is often the next stop, and then, for some, the shelter system. A 1982 study of new shelter residents in New York City revealed that 61 of 617 men interviewed had spent the previous night in a single-room-occupancy hotel.[33] This phenomenon of displacement has been taking place for more than a decade in New York City.

THE STORY OF THE GREENWICH HOTEL: A PARADIGM OF GENTRIFICATION

The Greenwich Hotel, as it was called in the late 1960s and early 1970s, occupied an eight-story structure in the midst of the entertainment area of Manhattan's Greenwich Village. The surrounding district is occupied largely by middle-class families. It was constructed in 1893 for poor, single, working men.[44] (See Figure 1.1.) Theodore Dreiser is said to have lived in the building, then known as the Mills Hotel No. 1, while he was writing *Sister Carrie.*

In the 1930s the occupants were aged victims of the depression. (See Figure 1.2.)

By the late 1960s it had become a giant SRO, or "welfare hotel." The eight floors of the building had been converted into 1400 cubicles,

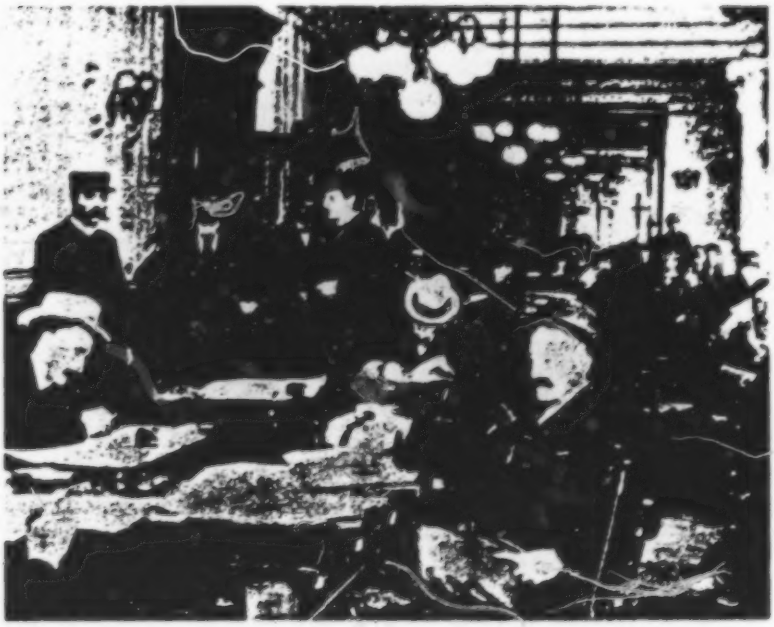

Figure 1.1. The Hotel Interior, 1897 (From Brickner, PW, Kaufman, A Case finding of heart disease in homeless men. Bulletin of the New York Academy of Medicine, Second Series, Vol. 49, No. 6, p. 476. Copyright © 1973 by the New York Academy of Medicine. Reprinted with permission.)

measuring five by seven feet. Homeless, destitute men were referred to the hotel by the then Department of Social Services of New York City for placement. At the maximum, 1200 people were in residence.

The men fell into three general categories: chronic alcoholics, heroin addicts, and the elderly. About 20 percent of the hotel population were aged men living a marginal existence on social security payments, periodic employment at menial jobs, or welfare. About 35 percent of the men were chronic alcoholics, usually unemployed and living on welfare. The rest, almost half, were heroin addicts, a number of transvestite homosexuals among them, recently released from prison and referred to the hotel by the social service authorities. These men depended on welfare payments as their only legitimate source of income and preyed upon the elderly and alcoholics for money to support their addiction.

Figure 1.2. The Hotel Interior, 1933 (From Brickner, PW, Kaufman, A. Case finding of heart disease in homeless men. Bulletin of the New York Academy of Medicine, Second Series, Vol. 49, No. 6, p. 477. Copyright © 1973 by the New York Academy of Medicine. Reprinted with permission.)

The hotel management attempted to keep these groups separated by floors and room assignments, but access to all floors was easy. Consequently the younger, more aggressive men freely abused the others. At night the hotel became a jungle in which the aged and disabled barricaded themselves in their rooms or were subject to assault.

Most of the men spent their idle hours loitering in front of the building, hustling for change or drugs in the neighborhood, or wandering in the local park. (See Figure 1.3.)

The reaction of community people to the hotel and to the men themselves was predictable. Local merchants felt that the hotel residents created a negative effect on their trade. Burglaries, muggings, and purse snatchings in the area were generally attributed to these men. After a pedestrian was killed by a table thrown off the roof, pressure was placed upon the mayor's office and the Department of Social

Services to stop supporting welfare clients at the hotel, a policy which took effect in May 1971. All residents whose rent was paid by the city were given the addresses of other welfare hotels. The men left; the political agitation abated. The problem was solved by moving it elsewhere. In later years, as other such buildings closed, many of these people were forced into the streets.

The building ownership was taken over by a real estate entrepreneur, and after reconstruction was reopened in the mid-1970s as a condominium called the Atrium. (See Figure 1.4.)

Figure 1.3. The Hotel, Street Scene, 1971 (From Brickner, PW, Kaufman, A. Case finding of heart disease in homeless men. Bulletin of the New York Academy of Medicine, Second Series, Vol. 49, No. 6, p. 479. Copyright © 1973 by the New York Academy of Medicine. Reprinted with permission of the copyright holder and photographer.)

Figure 1.4. The Atrium, Photograph of the Conversion, 1983 (Reprinted with permission of the photographer, Maria Lagudis Lechich.)

INDICES OF DISEASE

Health care for the homeless must deal with the effects of trauma, both major and petty; infestation with scabies and lice, and the skin infections that ensue; peripheral vascular disease, cellulitis, and leg ulcers that stem from the dependent positions in which these men and women keep their legs day after day; alcohol and drug abuse; plus all the standard medical illnesses, including cardiac disease, diabetes mellitus, hypertension, acute and chronic pulmonary disease, and tuberculosis. These matters are reviewed in succeeding chapters. Earlier experience[2,3,45,46] shows that medical problems of SRO residents are similar. (See Table 1.3.)

Clinics were conducted at four SROs in New York City from 1969 through 1972. Seven hundred and forty-three men were seen in a total of 2624 visits. The most common health problems were related to alcohol abuse. Trauma, leg ulcers, cellulitis, and respiratory infection were frequent complaints. Eighty-five men had a history of overt psychosis, and many had been patients in state psychiatric hospitals. Two patients committed suicide in the SROs during this period, and one was murdered.

CHALLENGES

> Since then, whenever in the course of my life I have come across, in convents for instance, truly saintly embodiments of practical charity, they have generally had the cheerful, practical, brusque and unemotioned air of a busy surgeon, the sort of face in which one can discern no commiseration, no tenderness at the sight of suffering humanity, no fear of hurting it, the impassive, unsympathetic, sublime face of true goodness.[47]

What is the measure of success for people who work in shelters for the homeless? Often, small improvements in the lives of patients are triumphs. Failure is common, and for health workers the ability to sustain a sense of satisfaction and purpose is a test of character. Homeless individuals are often alienated, confused, frightened. Their behavior, by orthodox standards, is frequently self-defeating. For some, disability appears preferable to good health.

> Patient A.B., a 65-year-old man, was induced to come for treatment of a massive leg ulcer due to venous stasis, trauma and neglect.

Table 1.3. Incidence of Medical Diagnosis in Four New York City SROs: 1969–1972

Diagnosis	*Number*
Acute or chronic alcoholism	160
Drug use, intravenous or subcutaneous	102
Psychosis	85
Trauma	80
Assaults	32
Accidents	38
Burns	10
Respiratory infections	76
Active pulmonary tuberculosis	11
Cardiovascular disease	54
Leg ulcers, cellulitis	41
Acute gastrointestinal disease	22
Seizure disorders	21
Jaundice or ascites	20
Insect infestation	20
Venereal disease	6
Gonorrhea	4
Primary syphilis	2
Osteomyelitis	2

The patient had visited the emergency rooms and outpatient departments of local hospitals but had always refused hospital admission and did not keep clinic appointments. The ulcer involved the entire anterior and lateral surface of the left leg below the knee. Exuberant granulation tissue made the circumference three times that of the right leg. When the patient was first seen, purulent, foul-smelling draining was marked, despite any benefits rendered by the maggots found in the lesion.

Treatment lasted for ten months and consisted of warm antiseptic soaks up to five times per week, sterile dressings, and oral antibiotics. Although the patient was persuaded to visit the clinic daily, he often refused soaks and antibiotics. Improvement was slow.

When reepithelialization was almost complete and drainage minimal, the patient refused to return to the clinic. When observed casually by physicians and nurses, the patient would not discuss his leg, which was seen to be reinfected; the newly formed skin had been destroyed, and gross purulent drainage was present.

When last observed, the patient was semicomatose on the floor. The leg was gangrenous. He was removed to the hospital.[45]

In order to fulfill acceptable standards of humane care for homeless people, health services need to be developed. Creation and training of health care teams in shelters serving the homeless is the first essential step in meeting our obligation. Maturity, self-confidence, and life experience are important assets for staff members.

Voluntary agencies, private philanthropies, and government at all levels must accept the appropriate degree of financial responsibility. Hospitals; workers in the fields of medicine, nursing, and social work; and community agencies must plan together to achieve practical results.

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Mr. WAXMAN. Our last panel consists of advocates for the homeless. Tipper Gore and Janet Waxman are the co-chairs of Families for the Homeless. They are here today on behalf of the National Mental Health Association, the National Alliance for the Mentally Ill, and the Mental Health Law Project. They will be accompanied by John Ambrose and Joseph Manes.

Maria Foscarinis is Washington Counsel for the National Coalition for the Homeless. She has been of great assistance to the subcommittee in developing this hearing.

I want to welcome all of you to the hearing today. We are looking forward to hearing your testimony. It is a pleasure to have with us Janet Waxman, my wife, and Tipper Gore, the wife of Senator Al Gore, but we are not going to treat you any differently than any other witnesses. Why don't we start off with Mrs. Gore.

STATEMENTS OF TIPPER GORE; AND JANET WAXMAN, ACCOMPANIED BY JOSEPH MANES, ON BEHALF OF NATIONAL MENTAL HEALTH ASSOCIATION, NATIONAL ALLIANCE FOR THE MENTALLY ILL, AND THE MENTAL HEALTH LAW PROJECT; AND MARIA FOSCARINIS, WASHINGTON COUNCIL, NATIONAL COALITION FOR THE HOMELESS

Mrs. GORE. Thank you very much, Mr. Chairman. It is my pleasure to be here today. My name is Tipper Gore. Janet Waxman and I are pleased to have this opportunity to appear before this committee on behalf of the National Mental Health Association, the Mental Law Project, and the National Alliance for the Mentally Ill. With us are representatives of these groups who are available to provide detailed information at your request.

Janet will discuss recommendations concerning the federal-state medicaid program. In my testimony, I will discuss provisions of H.R. 5137, Health Care for the Homeless Act. At this time, I would like to submit for the record our written statement, which describes in detail our recommendations.

Homelessness, Mr. Chairman, is a complex problem which demands the commitment and involvement of all Americans. Each of us is capable of doing something to help. In recognition of this, Janet and I have been working with other family members of Members of Congress, the administration, and those who work in the media to raise public awareness about homeless people and their needs.

This past May over 70 of these family members announced the formation of a unique nonpartisan partnership called Families for the Homeless. We are currently working on ways to educate the public and public officials about the growing needs of the homeless population.

We realize that the realities of today's homeless people have outstripped the stereo-typical image that people have, and that the fastest growing part of the homeless population are children, and women and children, and if we continue at this rate, we are going to see a generation of children that are raised beyond poverty.

We thought that one of the greatest ways to blast away some of the stereotypes and perceptions was through a photographic exhibit and that is what we organized last May. It was held in the Ro-

tunda of the Russell Senate Office Building. We feel that that was a successful way to reach people, through powerful images. We had five photographers representing five different regions of the country display their works with the support and help of the National Mental Health Association.

I appear before you today as a member of the Board of Directors of the National Mental Health Association, and with Janet, as a member of the Association's Task Force on the Homeless Persons Survival Act. Homelessness is the shame of America, and while we try to get a grip on statistics, we must pay attention to the people that we saw here earlier today with their very real needs and their shattered dreams, and offer them the help that should be America's honor.

Literally hundreds of thousands of children, families, women, veterans, young men just going out in life, and others, are living in the streets and cars and alleyways, in conditions that are appalling and not fit for fellow Americans. As we have heard this morning from the other witnesses, these individuals are found in all regions of the country, in both urban and rural settings.

While there may be some disagreement over the size of the homeless population, there is agreement from all sectors that homelessness is increasing at truly shocking rates. U.S. Conference of Mayors, for example, estimates the homeless population increases annually by 25 percent. Therefore, it is essential to plan and fund now in order to respond to what is truly a national crisis.

Another area of agreement is that the response of cities, counties and volunteer organizations, while noble, is inadequate. Not even sufficient emergency shelter is being provided, to say nothing about health, mental health and long term housing and employment needs.

For example, the Housing and Urban Development survey estimates that there are 111,000 available shelter beds nationwide. HUD also estimates that there is a minimal homeless population of 250,000 people. Of course, I think we all realize that the real number is much, much larger, and some estimates are in the millions.

A comprehensive approach is necessary in designing solutions to the problem. It is complex. People do not choose the situation. They are not there because they are some romantic hobos, as has been mentioned in the past. This is especially true for the most vulnerable part of the homeless population, those who suffer some mental illness, some mental disorders. These persons need a range of special services, including mental health intervention where they are, but perhaps most of all, they do require the means and the help to have a decent life and to have some shelter from the storm.

The Reagan administration has formally withdrawn from this issue, ascertaining there is no federal role. Mr. Chairman, Congress cannot and must not similarly abdicate its responsibility to these people. Clearly the task of meeting the needs of homeless persons, in designing the strategies for homelessness is beyond the resources of private groups, and bigger than the resources of state and local governments—at least what they are willing to commit at this point. Only the Federal Government has the capacity to mount a national effort to reduce the debilitating effects of homelessness

and to address the root causes of the problem. How else, Mr. Chairman, can the concerted consciences of a nation express itself except through the logical vehicle of federal action?

And should not this action be skillful and well planned, and well funded? When there is no one else to care for the most vulnerable human beings in our society, the Federal Government must act as the nation's conscience. Otherwise, we have no conscience.

While it is beyond this committee's ability to deal with all the issues, it is important to state that federal policies need to be adapted in order to insure that mentally ill individuals who are homeless, have appropriate access to housing at a price they can afford, to residential services, if needed, to maintain them in such housing, disability income through supplemental security income or social security disability, insurance programs, food and access to food stamps.

As their situation improves, as some surely will, in order to enable them to function at their highest potential, they may also require vocational rehabilitation services, and other assistance in gaining employment and a vocation.

It is because of these diverse needs that Congressman Leland, with Mr. Waxman and more than 30 co-sponsors in the House, and Senator Gore, have introduced the Comprehensive Homeless Persons Survival Act. H.R. 5137, which authorizes federal funds for health and mental health services for homeless individuals, is part of this comprehensive bill. It is the first piece of national legislation to take a comprehensive approach to the problem of homelessness, and to specifically address the needs of chronically mentally ill persons. And I understand that there is from 25 to 50 percent of the homeless population that can be considered to suffer from mental disorders. It does this by amending existing laws in order to strengthen the so-called social safety net.

The bill approaches the problem from three different perspectives:

One, to alleviate the suffering of those who are homeless, it provides emergency relief.

Two, to stem the continuing growth of homelessness it proposes a number of preventive measures which are very important.

And three, to insure that shelters do not become permanent living arrangements, it proposes a long term approach by restoring desperately needed federal low cost housing for those who cannot afford a decent home. What good is progress and material wealth on one level if the process displaces families and individual with no thought to where they go? In human terms, the cost of such a great society is too high.

H.R. 5137 is one of the seven bills in the House that comprise the Homeless Persons Survival Act. The bill addresses the mental health and health needs of persons who are homeless by authorizing $140 million for a program of grants to public and private agencies to furnish health and mental health services. This would make funds available for the most basic and necessary types of services, and emphasizes the need for those services to be accessible, as we have heard the homeless individuals who suffer a mental disorder.

Unfortunately, the need is so great that this $140 million authorized is probably insufficient and we urge that as the legislation is considered the funding for this particular item be increased.

We also suggest a few modifications in this legislation:

One, that references to mental health care should clearly state that such services are to be provided on an outpatient basis. The bill uses the term "outpatient" to describe the health services covered, but does not include the same qualifier for mental health services.

Two, that programs funded under this legislation should be authorized to provide advocacy services for mentally ill individuals who are homeless, perhaps in cooperation with the state protection and advocacy programs for mentally ill persons.

Three. Many of the services authorized, particularly the outreach services, can be most effectively provided by consumer run programs that provide self-help services.

In addition to these changes to H.R. 5137, we would also strongly urge changes to medicaid, which Mrs. Waxman will describe.

When the Homeless Persons Survival Act is introduced next year, re-introduced, it should contain these improvements. Also, Mr. Chairman, the budget resolution needs to include an allocation addressing the needs of homeless persons.

In conclusion, in a few short days winter will once again officially arrive. Also hundreds of thousands of Americans will have to struggle just for survival, because there is not yet a comprehensive federal strategy on homelessness. Let's not let the cold and federal inaction claim more lives. We urge this committee to act quickly to enact these recommendations when the 100th Congress reconvenes in January.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Janet.

STATEMENT OF JANET WAXMAN

Mrs. WAXMAN. Good morning. I am particularly pleased to have the opportunity to appear before such recognized leaders in national health care for the poor.

My particular concern is for the homeless centers around Los Angeles, where some 50,000 men, women and children live on the streets. 50,000, the largest concentration of homeless in the country—making Los Angeles the so-called homeless capital of America. Los Angeles not only has the largest number of people living on the streets; given that number; understandably, it also has the largest number of people dying on the streets—dying of exposure.

Perhaps 25 to 50 percent of those 50,000 are chronically mentally ill, and it is this particular population that I want to discuss today because there are almost no programs for seriously mentally ill, particularly for those people who have been out on the streets for a long time. Fortunately there are some successful programs, and these can be duplicated.

One such program that uses private funds is the Downtown Women's Center on Skid Row in Los Angeles, there, success is providing a full service drop-in center meal, and attractive, new, low-

cost housing. Its founder, Jill Halverson, believes that most of the women there will need to live their lives out at the center. At another center, Fountain House in New York, which uses private, state and local government money, the emphasis is on rehabilitation, and success is having clients get full or part time jobs and providing support services and low cost housing

So there is no shortage of successful, model programs. What we lack is a shortage of funds to duplicate them, with charities and state and local governments saying they can't do it alone.

The National Mental Health Association, the National Mental Health Law Project, and the National Alliance for the Mentally ill have developed proposals for federal action based on such existing successful programs. I commend these proposals for your consideration:

First, we need more outreach programs, such as Project Outreach in New York, where concerned people reach out to people where they live, on the streets—first establishing trust, and then, and only then, offering mental health services and rehabilitation.

We need more of this "first establish trust and then offer services" approach in shelters and soup kitchens.

We need more drop-in day care programs where people can get food, companionship, mental health services, rehabilitation and vocational services—where people can learn things like how to keep an appointment and how to get along with others.

Finally, we need more group homes where people can learn these skills and also can learn domestic skills to be able to live more independently.

A number of these recommendations could be implemented with relatively small expansion in the medicaid program. I hope as you consider revisions in the Leland-Waxman Health Care for the Homeless Bill, you will give consideration to these proposals.

Thank you very much.

[Testimony resumes on p. 105.]

[The prepared statement of Janet Waxman and Tipper Gore and attachment follow:]

TESTIMONY

by

JANET WAIMAN and TIPPER GORE

Mr. Chairman, and members of the Committee, we are pleased to be here today to present testimony on the needs of those with mental illness who are homeless. Our statement is presented on behalf of the National Mental Health Association (NMHA), the Mental Health Law Project and the National Alliance for the Mentally Ill (NAMI). These organizations act as advocates on behalf of individuals with mental illnesses.

It has been our pleasure to work with these and other national organizations as we -- together with colleagues whose spouses also are in Congress or the Administration or working in the media-- have joined together, in a non-partisan way, to develop a campaign to increase public awareness about homelessness and the needs of persons who are homeless.

Today we are pleased to bring to this Committee some of the concerns and recommendations of these three national organizations about the mental health and health needs of persons who are homeless. Tipper Gore is a member of the NMHA Board of Directors, and we both are members of the NMHA Task Force on the Homeless Persons' Survival Act.

Homelessness in America is no longer limited to white male, chronic alcoholics and "bag people," but now also affects as diverse a population as can be found in our country: families with children, the elderly, recently undemployed, mentally and physically disabled, and members from a range of minority groups. These individuals can be found in all regions of the country, in both urban and rural areas.

Most current efforts on behalf of homeless people are short term and emergency oriented -- band-aids on bits and pieces of the total problem. There is very little in the way of a comprehensive effort being undertaken. What is needed is a national strategy.

While the federal government has done practically nothing, homelessness is growing at a rate not seen since the Great Depression. Estimates from the best informed relief agencies number homeless people anywhere from the hundreds of thousands to the millions. While there may be disagreement on the number of Americans who are homeless, there is agreement among such diverse groups as the U.S. Conference of Mayors, the General Accounting Office, the FEMA National Charities Board, the National Coalition for the Homeless, and others that the number of persons becoming homeless is increasing. (1) The 1985 survey by the U.S. Conference of Mayors, for example, found that the homeless population increases annually by about 25 percent.

The causes of homelessness are complex and diverse, and many factors combine to force an individual or a family into homelessness. Once homeless, the problems facing these people as they try to bring their lives back together are enormous, and for those with mental illness, such a task is overwhelming.

According to statistics from the National Institute of Mental Health, between thirty and fifty percent of homeless persons have a serious mental illness -- schizophrenia, organic brain syndrome, major affective disorders, and severe dysfunctional personality disorders. This population, unlike those who are transiently traumatized by being homeless, risk serious long-term disability and sometimes fatal consequences on the streets.

All individuals who are homeless, including those with mental illness, suffer a range of health problems. Constant exposure to the environment, inadequate nutrition, perpetual walking, sleeping upright, vulnerability to criminal assault, life in the shelters and soup kitchens: all these are aspects of a life of homelessness with direct and strongly deleterious effects on physical health. Many of the ensuing health problems are, or can be, life-threatening if untreated, and many are indeed untreated. There is probably more untreated disease among homeless persons than among any other identifiable group in the American population. (2)

Comparisons between a sample of homeless people and the National Ambulatory Medical Care Survey (NAMC) confirm that homeless persons are at much higher risk from many diseases, particularly those linked to alcohol use and those resulting from environmental exposure. (3) For example:

- Diseases and disorders of the extremities are considerably more prevalent (by a factor of fourteen) among homeless people than among the NAMC sample, and likewise neurological disorders (by a factor of six), chronic lung desease (also by a factor of six), liver and related diseases (by a factor of five), and nutritional disorders, acute upper respiratory ailments, teeth and mouth diseases, unreferred symptoms and conditions (all by a factor of approximately four). (4)

- Homeless persons test for active tuberculosis at 100-200 times the rate for the general population,(5) and five hundred of every 100,000 homeless alcoholics test positively for tuberculosis each year.(6)

- The Manhattan Bowery Project evaluated 200 patients and found that 22 percent of the men were afflicted with dermatological diseases, among which skin ulcers, lacerations, and contusions predominated. A 1973 study reported 41 out of the 434 patients, or 10 percent of the study population, to have leg ulcers or cellulitis." (7)

Persons who are homeless and seriously mentally ill are among the most vulnerable and disenfranchised clients in our health and welfare systems. While they share characteristics and needs of the homeless population generally, their mental illness demands special approaches to end their homelessness.

Contributing to the inadequacy of community care are major problems relating to funding, unclear or antithetical legislation, eligibility determination factors which exclude mentally ill people from benefits which they need, poor planning of services and lack of coordination of services and program accessibility.

According to the National Institute of Mental Health, certain functional characteristics -- extreme vulnerability to stress, difficulty with tasks of daily living, odd behaviors, episodes of "acting out," and problems negotiating bureaucratic systems -- tend to make mentally ill persons susceptible to becoming homeless and less responsive to traditional treatment strategies. The stigma accompaning mental illness often place these individuals in precarious economic circumstances and exclude them from true integration into the community. The cyclic and chronic nature of the illness may, for example, interfere with the person's capability to work. Without earned income, many must depend on the fragmented patchwork of federal, state, and local government

social programs. Yet mentally ill individuals often experience difficulty gaining access to and establishing eligibility even within these well-intentioned programs.

The severe shortage of affordable residential options, as well as an insufficient number and range of supervised and supported residential beds, prevents the successful integration of many chronically mentally ill persons into the community. They are also at a disadvantage in the highly competitive low-cost housing market. Furthermore, elderly and physically disabled persons frequently are preferred tenants for public housing for the handicapped.

Neither the services nor the support system -- the so-called "social safety net" -- intended for America's neediest population groups are specifically designed to meet the needs of chronically mentally ill individuals. The mental health system also is not always appropriately responsive to the needs of individuals with severe mental illness, especially those with other problems, such as substance abuse, mental retardation, or those who are particularly treatment resistent.

Some homeless mentally ill persons shun traditional treatment settings because of their prior institutionalization in state hospitals, unsatisfying experiences with mental health programs, or just the unwillingness to acknowledge that they have a serious problem. Realistically, they may also fear that if their mental illness is detected, they will be committed involuntarily.

Others have rejected traditional services because they feel that they will not receive the help they need, more, however, welcome treatment. One study, for example, showed that in Philadelphia more than 84% of homeless individuals voluntarily complied when offered psychotropic medication. (8)

More commonly, however, seriously mentally ill homeless persons are denied access to mental health care. The assumption that mental health services will automatically be rejected often fuels the inertia of bureaucracies that are not eager to extend appropriate care.

Mental health personnel who provide care for this population must be sensitive to the unique characteristics of homeless persons and must be flexible, nonthreatening, and accessible. Experience has shown that services initially offered on the street, from in a mobile outreach van, or in a shelter or soup kitchen are much more successful in reaching those on the street than services provided in traditional office settings. Far too often, we unsuccessfully attempt to make our patients conform to our service system rather than modify our system.

Despite this bleak picture, there are effective programs furnishing services to homeless mentally ill persons, and having success. One example is a pioneering community support-rehabilitation program for persons who are homeless and those with a mental illness sponsored by Boston University and St. Francis House.(9) As a first step in establishing rapport and trust, this program attempts to provide basic supports, counseling, case management, and on-site medical services. Next, they involve clients in a more active psychosocial rehabilitation program. Although the program is new, its developers report

high levels of participation and good results in linking homeless mentally ill clients to services.

Recommendations for Federal Action

Unfortunately, most of the major federal entitlement programs -- such as Medicaid and Medicare, SSI, SSDI, and Food Stamps -- do not adequately provide for persons with a chronic mental illness, particularly those who are homeless. Many of the community-based services which people with mental illnesses require are not covered under Medicaid or Medicare. Mentally ill persons often do not receive the benefit of other federal programs because of restrictve standards of eligibility based on "disability" or "illness" or because of organizational or jurisdictional confusion.

Individuals who are mentally ill and homeless need a range of specific services, including mental health intervention, but they also, perhaps most of all, require the means to live a decent life. While it is beyond this Committee's ability to deal with such issues, it is important to state that federal policies need to be adapted in order to ensure that mentally ill individuals who are homeless have appropriate access to housing at a price they can afford, residential services, if needed, to maintain them in such housing, disability income through Supplemental Security Income or Social Security Disability Insurance programs, food and access to Food Stamps. As their situation improves, in order to enable them to function at their highest potential, they may require vocational rehabilitation services and other assistance in gaining employment. It is because of these diverse needs that Congressman Leland with Mr. Waxman and over 30 other members of the House, and Senator Albert Gore Jr. have introduced the comprehensive Homeless Persons Survival Act.

The Homeless Persons Survival Act (H.R. 5140/S.2608) is the first piece of national legislation to take a comprehensive approach to the problem of homelessness. It does this by amending existing laws in order to strengthen the so-called "social safety net." The bill approaches the problem from three perspectives: (1) To alleviate suffering of those who are homeless, it provides emergency relief; (2) to stem the continuing growth of homelessness, it proposes a number of preventive measures; and (3) to ensure that shelters do not become permanent living arrangements, it proposes long term approaches by restoring federal low-cost housing for those who cannot afford a decent home.

H.R. 5137, which authorizes federal funds for health and mental health services for homeless individuals, is a part of this comprehensive bill.

The most immediate health and mental health needs of homeless mentally ill people now on streets are:

* outreach programs to identify homeless mentally ill people and to provide emergency assistance where the individual is now living (blankets, food, etc.) and which begin the slow process of engaging these individuals and building the necessary rapport to initiate mental health interventions;

- drop-in day programs, which serve a similar outreach purpose for those individuals willing to participate, where food, companionship, health services and mental health screening can be provided;

- mental health screening and initial treatment provided in shelters and other programs serving homeless individuals;

- access to mental health treatment services in the community -- including diagnostic evaluation, prescription of medications, emergency and crisis intervention services, case management, day psychosocial rehabilitation services and residential services;

- assistance in accessing other benefits to which they may be entitled.

Unfortunately, most homeless individuals have very little access to any of the above services.

At a recent meeting of community foundation officers, community service providers, and mental health professionals on the role of private community foundations in serving the needs of homeless persons with mental illnesses, a concerned Senate aide asked the group, "What is your experience with federal resources? Are these funds available?" The unanimous answer was an emphatic NO! Dr. Richard Surles, Administrator of the Mental Health/Mental Retardation program in Philadelphia told the group that the Social Services Block Grant, one possible source of funding for this population, has been cut since 1981, "and right now that is pitting the mentally ill against children." Local service providers reported they had limited, if any, success in accessing federal dollars. Dr. Surles also pointed out that, "strategies don't meet the standard fee-for-service, success-rate orientation of most programs. In Pennsylvainia, we are dealing with regulations that haven't changed in years, and they don't apply to this population." (10)

HR 5137 addresses these issues by authorizing $140 million for a program of grants to public or private nonprofit agencies to furnish health and mental health services. The program would make funds available for many of the most necessary types of services, and emphasizes the need for such services to be accessible to homeless individuals. Unfortunately, the need is so great, it is doubtful that the $140 million authorized for these purposes will be anywhere near sufficient, and we urge that as the legislation is considered, the funding be increased significantly. We would also suggest a few modifications to this legislation, as follows:

- references to mental health care should clearly state that such services are to be provided on an outpatient basis (the bill uses the term "outpatient" to describe the health services covered, but does not include the same qualifier for mental health services);

- programs funded under this legislation should be authorized to provide advocacy services for mentally ill individuals who are homeless, perhaps in cooperation with the state Protection and Advocacy Program for Mentally Ill Persons, and

- many of the services authorized, particularly the outreach services, can be most effectively provided by consumer-run programs that provide self-help services.

In addition to these changes to HR 5137, we would also most strongly urge changes to Medicaid. Many homeless mentally ill individuals are eligible for Medicaid, due to their disability which qualifies them for SSI payments. Yet current Medicaid coverage of community mental health services is inadequate for individuals with chronic and serious mental illness, and especially for those who are also homeless and generally more disabled by their mental illness. Often these individuals also have multiple health problems, including substance abuse, which can make it hard to make accurate psychiatric diagnoses.

Current Medicaid policy not only fails to fund the types of services most needed by this population, but under rules issued in 1985 by the Health Care Financing Administration, expressly prohibits providers furnishing the most appropriate care. HCFA has decreed that to qualify as a Medicaid clinic service, mental health services must be furnished by clinic staff in the clinic facility. Thus, mental health agencies which send professionals to work with shelters in identifying and providing initial mental health intervention services cannot obtain Medicaid reimbursement for such services. Instead, HCFA expects that homeless mentally ill people, who, as described above, are often alienated against and afraid of the mental health system, who lack the funds and the skills to travel around town on public transportation, to present themselves (on appointment?) for services in a mental health center!

The effect of this HCFA policy has, of course, been to isolate mentally ill homeless persons even further from the help they need.

This policy could be reversed fairly easily. There are, however, more systemic problems with Medicaid which stem from the law itself. Medicaid emphasizes medical services, and fails to describe an adequate mental health benefit. Outpatient mental health services are covered under service options designed for general health care, such as outpatient hospital services, clinic services, etc. Psychiatric illnesses require a slightly different emphasis. In particular, serious and chronic mental illness is most effectively treated with a combination of physician services and psychosocial rehabilitation day treatment services. Outreach and case management services, important for all individuals with chronic mental illness, are particularly essential for homeless persons.

We therefore recommend the following changes to Medicaid.

1. The Medicaid clinic option should be amended to specifically cover outreach services furnished to Medicaid-eligible individuals outside of the clinic facility, and which are designed to locate clients, inform them of available services and initiative diagnosis and treatment.

2. The clinic option should be further amended to cover the cost of mental health services in drop-in day programs for homeless individuals where mental health intervention as well as other services can be offered.

3. The Social Security Act should be amended to give states the option to cover psychiatric rehabilitation services, recommended by a physician, including: psychosocial rehabilitation services, such as training in personal and community living skills (medication use, meal preparation, budgeting, housekeeping, use of transportation, etc.), mental health services to assist the individual in employment, social rehabilitation, re-motivation, health improvement, and activities to retain and maintain supportive living in a community setting.

4. The Act should be further amended to give states the option to cover residential services, other than room and board, for seriously mentally ill individuals who require supported living arrangements.

In conclusion, Mr. Chairman and Mr. Leland, we are asking for action. Action by the federal government, and action now.

We recognize that the Administration does not plan to act, and we urge that Congress therefore take the initiative. We support a range of federal policy changes to aid homeless persons, as envisioned in the Gore-Leland Homeless Persons Survival Act. We urge this Committee to act on the health and mental health portion of that legislation introduced in the 99th Congress as HR 5137 and also that you act to make the changes to Medicaid which we have cited today.

In many parts of the country, severe winter has begun. Let us act before the next snow falls.

FOOTNOTES

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2. Wright, James D., et. al, "Homelessness and Health, The Effects of Lifestyle on Physical Well-being Among Homeless People in New York City, The Social and Demographic Research Institute, (University of Massachusetts, Amherst), 1986, p. 39.

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The Fountain House Model of Psychiatric Rehabilitation

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Editor's Note: "The Fountain House model" is a phrase that is often heard and seen in the literature, at conferences and seminars, and just about anywhere rehabilitation practitioners are gathered. As concepts become popular they take on different meanings to different people. The editors of the Psychosocial Rehabilitation Journal *thought it important for our readers to know the latest up-to-date information about the Fountain House model as seen through the eyes of Fountain House.*

The Fountain House model is a social invention in community rehabilitation of the severely disabled psychiatric patient. Fountain House itself is an intentional community designed to create a restorative environment within which individuals who have been socially and vocationally disabled by mental illness can be helped to achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

Fountain House conveys four profoundly important messages to every individual who chooses to become involved in its program:

1. Fountain House is a club and, as in all clubs, it belongs to those who participate in it and who make it come alive. As with all clubs, participants in the programs at Fountain House are called, and are, members. The membership concept is considered a fundamental element of the Fountain House model. Membership, as opposed to patient status or client status, is regarded as a far more enabling designation, one that creates a sense of the participant's belonging, and especially of belonging to a vital and significant society to which one can make an important contribution and in which one can work together with fellow members in all of the activities that make up the clubhouse program.
2. All members are made to feel, on a daily basis, that their presence is expected, that someone actually anticipates their coming to the program each morning and that their coming makes a difference to someone, indeed to everyone, in the program. At the door each morning every member is greeted by staff and members of the house, and in all ways each member is made to feel welcome in coming to the clubhouse.
3. All program elements are constructed in such a way as to ensure that each member feels wanted as a contributor to the program. Each program is intentionally set up so that it will not work without the cooperation of the members; indeed, the entire program would collapse if members did not contribute. Every function of the program is shared by the members working side by side with staff; staff never ask members to carry out functions which they do not also perform themselves.

To create a climate in which each participant feels wanted by the program is the third intentional element in the Fountain House model. It is to be seen in stark and radical contrast to the atmosphere created in more traditional day programs, especially the attitude, almost universal in such programs, that persons coming to participate are doing so not because they are wanted by the program but because they are in need of the services provided to them by the program.

4. Following from the conscious design of the program to make each member feel *wanted* as a contributor is the intention to make every member feel *needed* in the program. All clerical functions, all food purchases and food service, all tours, all maintenance, and every other ongoing function of the clubhouse program are carried out jointly by the staff and members working together. Fountain House thus meets the profoundly human desire to be needed, to be felt as an important member of a meaningful group, and at the same time conveys to each member the sense that each is concerned with all. Mutual support, mutually caring for the well-being, the success, and the celebration of every member is at the heart of the Fountain House concept and underlies everything that is done to ensure that every member feels needed in the program.

These four messages, then, of membership, of being expected, being wanted, and being needed constitute the heart and center of the Fountain House model.

Additionally the model is informed with four fundamental and closely related beliefs:

1. A belief in the potential productivity of the most severely disabled psychiatric client.
2. A belief that work, especially the opportunity to aspire to and achieve gainful employment, is a deeply generative and reintegrative force in the life of every human being; that work, therefore, must be a central ingredient of the Fountain House model; that work must underlie, pervade, and inform all of the activities that make up the lifeblood of the clubhouse.

Thus, not only are all activities of the house carried out by members working alongside staff, but no opportunity is lost to convert every activity generated by the clubhouse into a potential productive contribution by members. Such involvement in the work of the clubhouse is a splendid preparation for and source of increased confidence in each member's ability to take gainful employment in the outside world.

Further in support of this profoundly held belief, Fountain House guarantees to every member the opportunity to go to work in commerce and industry at regular wages in nonsubsidized jobs (see Transitional Employment Program, below). Indeed, Fountain House considers this guarantee part of the social contract that it makes with every member.

3. As a parallel concept to that of the importance of work and the opportunity to work is the belief that men and women require opportunities to be together socially. The clubhouse provides a place for social interchange, relaxation, and social support on evenings, weekends, and especially holidays, 7 days a week, 365 days a year.

4. Finally, Fountain House believes that a program is incomplete if it offers a full set of vocational opportunities and a rich offering of social and recreational opportunities and yet neglects the circumstances in which its members live. It follows that the Fountain House model includes the development of an apartment program, which ensures that every member can live in adequate housing that is pleasant and affordable and that provides supportive companionship.

Program Components

The following program components of the Fountain House model will be seen to flow naturally and logically from the underlying concepts discussed above.

- the prevocational day program
- the transitional employment program (TEP)
- the evening and weekend program (seven days a week)
- the apartment program
- reach-out programs
- the thrift shop program
- clubhouse newspapers
- clubhouse name
- medication, psychiatric consultation, and health
- evaluation and clubhouse accountability

Prevocational Day Program

Fountain House believes that regardless of a member's apparent level of disability, each member has a significant contribution to make that is needed by the clubhouse setting and that will be valued and appreciated by others. Each has skills and talents that, when discovered and utilized, can make the experience of each day worthwhile. Fountain House believes that this process provides a new and nourishing foundation for the future.

The psychiatric patient returning to the community faces extraordinary difficulties in achieving vocational objectives. Employment interviewers in industry do not look favorably on previous psychiatric hospitalization. The psychiatric patient often lacks self-confidence in his or her ability to perform a job and typically does not have the job references essential in securing employment. The Fountain House prevocational day program provides many opportunities for members to regain vocational skills and capacities.

All of the day program activities are performed by members and staff working together. What everyone does is clearly necessary to the operation of the clubhouse. In working side by side with members the staff become aware of each member's vocational and social potential and the Fountain House member begins to discover personal abilities and talents that can lead to greater social effectiveness and more meaningful work.

In designing a program in which staff and members work together, Fountain House has brought about a major change in staff role from the role assigned in other, more traditional day programs. Role change necessitates attitude change on the part of the staff, specifically, that staff come to appreciate the members, to respect their contributions. In more traditional day programs the patients frequently respect and appreciate staff, but staff rarely have the experience necessary to appreciate and respect their patients.

Members find it helpful to work with staff and other members in the snack bar and kitchen/dining room areas, serving food to other members, helping to keep the area clean, maintaining equipment, and planning menus. Others find a meaningful experience in the clerical area, operating the busy switchboard, helping publish a daily newspaper or a monthly magazine, using typing skills as well as helping with essential clerical routines. There are also members who have talent in art and photography, and their skills can be further developed in the day program of Fountain House. Those who have special academic skills can utilize them in tutoring fellow members. Still others will find the thrift shop an environment where they can assist in sorting, pricing merchandise, and other warehouse activities, as well as acting as sales clerks and having opportunities to learn to use the cash register.

Where the educational background or interest of the members is appropriate, they can assist in research activities as well as educational programs, especially in the introduction of new members and visitors to Fountain House, in welcoming fellow members at the front door, in providing orientation for new members, and in conducting tours for the many visitors.

Members become involved in a profoundly important role, visiting other members who are at home or in the hospital, reaching out to those who have stopped coming to the clubhouse for whatever reason. Members also assist each other in working out their problems with welfare or social security regulations.

At Fountain House, as in other clubhouse settings, members view their daily participation in the prevocational day program as a "natural process" that is essential to the growth and well-being of all individuals. They are members of a club and voluntarily provide their help and assistance. They do not regard themselves as undergoing a formal rehabilitation process, in which something is being done to them. The goal is to establish a foundation of better work habits, enriched social skills, and a more helpful view of the future. Many discover that although they are viewed as disabled, there are many ways they can still be constructive, helpful, and needed.

In time, this newly discovered self-awareness can be translated into a more rewarding, nondisabling way of life, free of financial dependency and perpetual patienthood.

In brief, the prevocational day program provides a diversified range of clubhouse activities that clearly need to be performed and that, if reasonably well done over a period of time, will not only be personally rewarding to individual members but in a most fundamental sense will give them the self-confidence and awareness that they can successfully handle a job of their own or an entry-level job in the business community. These opportunities are guaranteed to all Fountain House members through the transitional employment program.

Transitional Employment Program (TEP)

Successful participation in the prevocational day program encourages many members to look forward to independent employment in the community. However, because they have often experienced considerable vocational failure, they lack confidence and necessary job references and are typically unable to secure employment on their own. The Fountain House transitional employment program makes it possible for members to work at jobs that other members have held before them and that industry has made available specifically to Fountain House to facilitate the work adjustment of the vocationally disabled.

The major ingredients of the transitional employment program are as follows:

1. All job placements for the severely disabled mentally ill are located in normal places of business, ranging from large national corporations to small local firms employing only a few individuals.
2. All job placements are essentially entry-level employment, requiring minimal training or job skills.
3. The prevailing wage rate is paid by all employers for each job position, ranging from the minimum wage to considerably above minimum wage.
4. Almost all jobs are worked on a half-time basis so that one full-time job can serve two members. A few TEP placements, however, are available on a full-time basis.
5. Most job positions are performed individually by a member in the presence of other workers or employees. Some job responsibilities, however, are shared by a group of six, eight, or even ten individuals from a community-based rehabilitation facility. In that case members relate primarily to one another on the job.
6. All placements, both individual and group, are temporary or "transitional" in design, providing employment for as little as three months to as long as nine months or a year.
7. TEP provides a guaranteed opportunity for disabled members to maintain temporary, entry-level employment through a series of TEP placements or to use such employment as a link or step to eventual full-time, independent employment.
8. Job placements are maintained only if the individual member meets the work requirements of the employer. No adjustment or lowering of work standards is made by employers.
9. Job failures on a TEP placement are viewed as a legitimate and essential experience for most vocationally disabled members in their effort to eventually achieve a successful work adjustment. Fountain House believes that the opportunity to fail on a job is a part of the total learning experience of working and that, although the sting cannot be totally eliminated from a member's experience of failure, it need not be the catastrophe it would be if it were perceived by the staff as a major defeat. In guaranteeing the member the right to fail, the transitional employment program at the same time guarantees the employer a worker. In setting up a TEP with employers Fountain House agrees that if a member does not come to work, another member or a staff person will be selected to do the job. No matter what an individual member's vicissitudes may be, employers can count on the job assigned to Fountain House being done every day.
10. In the work experiences of normal or nondisabled individuals, failure or withdrawal from entry-level employment often occurs, and TEP employers emphasize that job turnover rates are not typically greater for the vocationally disabled mentally ill on TEP placements than for the normal or nondisabled employee.
11. New TEP placements in the business community are always first performed by a staff worker for a few hours, longer if necessary, so that an accurate assessment can be made of the requirements that must be met if the job is to be handled successfully by individual members. Staff initiating new TEP placements are also able to evaluate the work environment and its compatibility with the needs of the vocationally disabled individual.
12. Through direct familiarity with the work environment, staff have immediate access to a work site whenever vocational difficulties occur that require prompt evaluation and assessment of a member's performance.
13. All TEP placements are allocated to Fountain House by the employer and the selection process to fill TEP placements rests with Fountain House and the individual members it serves.
14. No subsidy is provided to the employer with respect

to wages paid by the employer to a member on a TEP placement.

15. The unique collaboration or rehabilitation partnership between the business community and Fountain House is not a charitable act on the part of the employer. It is an agreed-upon arrangement that is of mutual benefit to the employer and the member who is seeking a higher, more rewarding level of work adjustment through the vocational services of the TEP.

16. The TEP provides a unique opportunity to enrich and expand the evaluation process concerning vocational potential and work adjustment. Assessment is made through guaranteed positions in a normal work environment, one that only the business community can provide, rather than through evaluations based solely on an individual's past work adjustment, performance in sheltered environments, or personal interviews and psychological assessment.

17. In the TEP it is not assumed that a member's prior history of vocational disability or handicap is necessarily indicative of his or her inability to successfully meet the minimal requirements of entry-level employment provided as a primary service within the supportive, comprehensive delivery system of a community-based clubhouse.

18. TEP placements remove or circumvent barriers that typically preclude or diminish the possibility that psychiatric patients will seek and secure entry-level employment:

a. A history of psychiatric hospitalization does not prevent the member from having the opportunity to secure entry-level employment.
b. No attention is given to the duration of a member's hospitalization, which may frequently be as long as 20 or 30 years or more.
c. The number of psychiatric hospitalizations is irrelevant to a member's opportunity to assume a TEP placement.
d. The absence of a work history, the presence of an extremely poor work adjustment, or lack of, or very poor, job references does not prevent or serve as a barrier to TEP work opportunities.
e. An individual's inability to pass a job interview is not viewed as a relevant to working on a TEP placement.
f. A TEP job placement is an opportunity guaranteed to all clubhouse members. It is not a requirement, therefore, for the disabled member to have sufficient motivation to seek employment independently. In the TEP it is believed that the ability of a member to perform a TEP placement productively is not necessarily correlated to the individual's motivation to seek employment independently.

The presence of guaranteed part-time, entry-level work opportunities within the rehabilitative environment emphasizes to the members that mental illness is not viewed as the sole or even primary explanation for vocational disability. It is, rather, a personal experience, one that typically prevented members from having normal opportunities to experience the real world of work and to develop capabilities to perform work productively and meet job requirements.

Transitional employment programs have been developed as a rehabilitative function of the normal work community. Although designed to meet the needs of the more severely disabled mentally ill, TEP placements have been integrated from the beginning with the work community rather than unsuccessfully simulating the real world of work, yet clearly separate and apart, as in the case of the sheltered workshop.

The Evening and Weekend Program

A primary difficulty for the more severely disabled psychiatric patient has been the inability to get along socially with others in the community. Discharged psychiatric patients typically find few opportunities for successful social interaction, remaining lonely and isolated in the community. This isolation is one of the crucial variables underlying the inability of many discharged patients to maintain their adjustment in the community and it often results in their return to the hospital.

The evening, weekend, and holiday social-recreational programs offered by Fountain House are designed to meet the members' needs for companionship and socialization. Fountain House members can experience being with each other, taking part in art programs, photography, chess and other table games, dramatics, chorus singing—indeed, in a rich and varied program. In addition members have the opportunity to be participants in outside volunteer-led activities such as bowling, movies, tours, theater, and sporting events.

It is important to note that the social-recreational programs of Fountain House are all conducted in the evening, on weekends, and on holidays, not during regular work hours as is often the case in other psychiatric day programs. They are specifically carried out during evening, weekend, and holiday periods because these are times when all other people are able to engage in social and recreational activities. Fountain House considers it counterproductive to the psychiatric patient's reintegration and success in the community to be engaged in recreational activities during what would otherwise be normal working hours.

The evening and weekend program enables members to maintain long-term contact with the clubhouse after they have become fully employed, which is of primary importance to their adjustment in the community. Such contact enables the member to continue to benefit from the supportive relationships developed at Fountain House, as well as from specific services such as the educational and employment programs. Members must know that there is assistance and encouragement available to them in their efforts to obtain a better job or to pursue their educational aspirations.

The evening program is also helpful to members when difficulties arise, such as when a job is lost or there is a recurrence of illness. Through the evening program, staff and members become aware of such problems and are able to assist the member who is in difficulty. This might involve helping someone to get to a clinic for a change in medication, or to become hospitalized, or to return to full-time participation in the Fountain House day program.

It has been found that the informality and openness of the evening and weekend program also eases re-entry into the rehabilitation environment for a member who has, for one reason or another, stopped coming to the program for a time or who has been rehospitalized.

The Apartment Program

Many psychiatric patients are without financial resources of their own when they are discharged to the community. Their sole support is often minimal income from public sources, which makes it extremely difficult to secure adequate housing. In the past the only alternative has been residence in a single-room occupancy hotel, a woefully undesirable alternative. More recently, discharged patients have been placed in other kinds of facilities such as family care homes, community residences, and halfway houses.

In an effort to provide less institutional, more normalized housing alternatives, Fountain House some years ago began to lease modestly priced apartments and to make them available to two or three members living together. It was felt that not only could Fountain House provide much more attractive apartments, furnishing them with contributions to the thrift shop, but that members living together could provide support, comfort, and understanding for each other. All apartments have kitchen facilities so that members may cook their own meals. Members pay their fair share of the rent and utilities.

Although the leases are initially held by Fountain House itself, it is entirely possible for a member or members to take on the lease once they have become stable and employed in the community. Apartments are located in various neighborhoods of New York City and many of them are located just across the street or in the immediate neighborhood of the clubhouse.

The apartments serve other important purposes. Resident members often host a new member who is still hospitalized and who is interested in exploring the kinds of living arrangements Fountain House provides as well as the activities of the clubhouse itself. With assistance from staff and other members, apartment residents have the opportunity to learn or relearn needed living skills, including housekeeping, cooking, budgeting, and getting along with a roommate.

Unlike almost all other community residential programs for mentally ill patients, residence in a Fountain House apartment is not time-limited; indeed, Fountain House does not perceive that any of its programs should be conceived of or presented to members as time-limited. On the contrary, Fountain House believes that members have the same right to seek independence at their own pace as do all persons growing up in a family and that if their growing is successful they have the same likelihood of achieving independence and separateness from the clubhouse family as does the growing person from his or her family. Just as in the family, where certainly no time limit is placed on membership, no time limit is placed on membership in any of the programs of Fountain House, including the apartment program.

Residence in a Fountain House apartment carries with it continuing active involvement in the clubhouse program as long as such participation facilitates the adjustment of the member. Fountain House does not provide apartments to individuals who are in need of housing but who are not at the same time seeking membership in the full Fountain House program.

Reach-out Programs

Often a member stops coming to Fountain House and it is not clear why he or she has done so. At other times a member requires rehospitalization. In both instances Fountain House feels that a reach-out effort from the clubhouse to the member is important, both to carry the message that the member is missed by fellow members and staff and to ascertain whether there is some way in which the clubhouse can help the member.

Both staff and members are involved in this critical reach-out effort. Increasingly it is felt at Fountain House that the reach-out function is peculiarly suited to members. It is often the members who first realize that a person has stopped coming; it is often other members who recognize that a person is becoming upset again and may need some counseling, some change of medication, or even a brief period of rehospitalization. It has also been learned that members take pride in and are effective in providing reach-out to fellow members.

The reach-out function is intended to convey important messages to members; not that they must come back to the clubhouse, but that they are cared about, that they are missed when they don't come, and that Fountain House will try to supply whatever assistance they may require.

The Thrift Shop Program

Many years ago Fountain House began to receive a number of telephone calls and written inquiries from people interested in its programs, some of whom expressed their willingness to make donations of goods they thought might be of value to Fountain House. A number of these inquiries came from individuals who knew of the Fountain House apartment program and who had furniture that they no longer needed but that was still serviceable

and that they hoped might help furnish an apartment for Fountain House members.

In response to these generous offers Fountain House established a thrift shop with several goals in mind. First, the shop makes possible the sale of donated goods at reasonable prices both to community residents and to members of Fountain House. The income from these sales converts donated goods into cash donations to the Fountain House program. Second, operation of the thrift shop provides opportunities for a variety of prevocational experiences for the members: warehousing, classifying, sorting and pricing merchandise, arranging merchandise attractively in the store, and meeting the public both as salespersons and as operators of the cash register. Volunteering in the thrift shop has been particularly appealing to, and effective for, older members.

Over the years, the thrift shop has grown both in the volume and in the variety of the items donated and subsequently offered for sale. Furniture, clothing, jewelry, and merchandise suitable for gifts are all available. The cash income derived from sales now makes a significant contribution to the total budget of Fountain House. The effort to attract donations from department stores and other retail outlets, factories, and individuals has led to a greater public awareness of the program and in some instances has led directly to active, invaluable involvement of individuals in Fountain House. For all of these reasons, the thrift shop has become a significant component of the Fountain House model.

Clubhouse Newspapers

Some years ago it was felt that there should be a vehicle for alerting members of Fountain House to the activities available within it and to current news about fellow members and staff. A clubhouse newspaper was established that from the beginning was a cooperative effort of staff and members. The newspaper contributes to bringing the membership together, it provides a variety of work activities in the prevocational day program, and it also serves as a very powerful communicating tool that informs staff and members of other clubhouses about Fountain House activities.

Members have the freedom to say what they wish about the programs of Fountain House, about experiences in the house, about successes and failures, in articles that they are free to publish. This helps both the members who write articles and the members who read them to experience a deepening sense of participant contribution to and shared responsibility for the club that they and the staff bring to life and help to flourish.

Clubhouse Name

Fountain House believes that one of the very significant acts a clubhouse program can undertake is to establish its own name. In many instances—and there are many—when a clubhouse is a component of a larger mental health consortium, such as a community mental health center, it is critical that the clubhouse establish its own identity and a separate location in its own building. The name of the clubhouse thus comes to signify not only its identity but also its independence as a program. The name also can reflect the feeling the program is meant to convey. For example, The Green Door suggests a welcoming place; more traditional names of facilities are often not as suggestive.

Medication, Psychiatric Consultation, and Health

Fountain House plays an important role in helping members maintain themselves on prescribed medication and in ensuring that they get required psychiatric care. Most of the members view medication as both necessary and helpful in their adjustment and they are of significant assistance in reinforcing this attitude among other members. Staff and members become aware when other members seem to be suffering a relapse and often help the member in getting to the clinic or hospital for assistance. Part-time psychiatric consultation is also available at Fountain House in emergencies.

Members and staff also help other members utilize community health facilities. This is extremely important to members who do not have the financial and personal resources to secure such help independently. In this important sense, Fountain House plays a crucial family role in encouraging members to get the care they are entitled to and require.

Evaluation and Clubhouse Accountability

Fountain House believes it is imperative that a continuing effort be made to evaluate the effectiveness of its programs, a belief shared by responsible community-based day programs for chronically mentally ill patients living in the community. Characteristically, however, the justification for the necessity of evaluations has been the staff's need to know the effectiveness of programs. Fountain House believes that this central reason for evaluation must include the members' right and need to know what kinds of successes and failures each of the programs of Fountain House is contributing to in the lives of fellow members.

In taking this position Fountain House considers itself to be in harmony with the concept emerging in the medical community that the patient has the right to know his or her temperature, pulse, diagnosis, and, further, that the fact of knowing will in itself positively contribute to the patient's recovery of health. Fountain House, in this analogy as in the family, is persuaded that the members' involvement in all aspects of the life of the clubhouse will have the same salutary effect, that is, that it will contribute to assisting members in achieving a high degree of self-confidence and productivity.

Fountain House considers it both natural and desirable that members themselves become significantly involved in

the procedures that are utilized to evaluate program effectiveness. The major evaluation effort currently undertaken by Fountain House and other clubhouse programs, the Categories of Community Adjustment Study, is therefore to a very large extent being carried on by members of Fountain House with the assistance and guidance of staff.

A Hints About the Future

Over the past 25 years Fountain House has come a long way toward learning how to create a restorative environment for chronically mentally ill patients living in the community. Fountain House has always been and is still acutely conscious that it has not fully realized all the implications of the concepts that underlie its efforts. A word should be said, therefore, about one direction in which Fountain House clearly sees itself going in the immediate future.

What Fountain House is now struggling with is a major increase in members' involvement in program delivery. It has already been noted that members are now taking major responsibility for the conduct of the Categories of Community Adjustment Study, a major element in the overall Fountain House effort to evaluate its program. Members are also increasing their involvement in the reach-out function at Fountain House. During the past two years Fountain House has been endeavoring to maximize a Member Training Project funded under a grant from the National Institute of Mental Health. The purpose of the project is to enrich and enlarge the degree to which and the ways in which members are encouraged to take increasingly active roles in crucial program delivery. Fountain House submitted the proposal not because it already knew how to extend and enrich member roles in clubhouse programs, but because it profoundly believes it is in an ideal position to pursue this goal, with the assistance of members in many clubhouse facilities.

It has indeed proved to be a challenging, difficult, and exciting effort. To date six roles have been identified in which members clearly take, and enjoy taking, major responsibility. The six identified roles are

- Categories of Community Adjustment Study
- reach-out
- member education and tutoring
- advocacy
- consumer literature
- rehabilitation plans

Over the next several years one of the most significant efforts of Fountain House will be carrying through the member training project and conscientiously putting into practice all that it will have learned. Thus, a bright and promising goal for the future of Fountain House is the fully realized utilization of members at maximum levels of involvement in the delivery of clubhouse activities.

A journal of the International Association of Psychosocial Rehabilitation Services and the Department of Rehabilitation Counseling, Sargent College of Allied Health Professions, Boston University

Mr. WAXMAN. Ms. Foscarinis.

STATEMENT OF MARIA FOSCARINIS

Ms. FOSCARINIS. Thank you. I would like to thank you, first of all, Mr. Chairman, for holding this hearing, and especially thank you for hearing as the leading panel from those who have direct experience with the misery of being homeless and in need of health care.

I would like to be brief in my oral testimony, particularly in light of the excellent presentations by my two colleagues on this panel.

This morning's Post reported that on Saturday a man was found unconscious in an abandoned building. He was taken to a hospital where he then died of hypothermia. In other words, a homeless man froze to death yet again. This event, noted almost in passing, is unfortunately not unusual. Each year unknown numbers of homeless persons freeze to death, die on the streets.

Death by exposure to the elements is the most dramatic and irreversible aspect of the health problems faced by homeless persons each day. Some of these deaths are noted, others go unmarked. Yet in spite of this, each year, months, days go by and no action has been taken by our national government to address this crisis. No serious national policy is now being implemented which could literally, quite literally, save lives.

Mr. Chairman, it should no longer be necessary to have to describe this outrage. It should no longer be necessary to have to describe the spectacle of Americans freezing to death on our streets because they have nowhere to go to get out of the cold. It should no longer be necessary to wonder why in this richest nation on earth Americans are forced to engage in a primitive struggle for their very survival. It is or it should be no surprise that, under these conditions, the primitive laws of nature take their toll on the health and on the lives of those who must struggle with them.

There is an obvious need for health care for the homeless. Yet as today's witnesses have graphically demonstrated, the poorest of the poor, the homeless, have virtually been cut out from whatever health care now is available to the poor. Isolated in shelters, abandoned on the street, homeless persons need immediate relief. They need medical treatment where they are. Medical clinics in shelters, regularly maintained, and federally assisted must be created. Outreach programs such as those described earlier must be expanded.

Finally, as was already pointed out, we must insure that the homeless have access to existing medical programs.

The Health Care for the Homeless Act, sponsored by yourself and others on this committee, Mr. Chairman, embodies these immediate emergency steps that must be taken now. Yet we must also look beyond these steps. Health care for the homeless is by definition a band-aid, by definition a temporary solution.

Being homeless is itself the biggest health risk, both mental and physical, a homeless person can face. Yet, long-term solutions are not mysterious. If we are really serious about the health needs of the homeless, let's get homeless persons off the streets and out of the shelters.

The true solution to homelessness is rather simple. We need housing. We need adequate affordable housing. Homelessness is now only the tip of an iceberg that can only grow. As affordable housing becomes scarcer, a serious, responsible and long-term approach to homelessness must include that component.

In the context of health care, it means affordable housing for those now suffering from pneumonia and frostbite on the streets, and for those risking tuberculosis in the shelters. In the context of mental health care, it means housing with special supportive services. This kind of comprehensive long-term solution is not impossible and it is not beyond our reach. As was already described, the Homeless Persons Survival Act introduced last summer embodies this kind of comprehensive long-term solution to homelessness.

About one month ago, President Reagan remarked on national television that he thought that the homeless in this nation were being taken care of by the Federal Government. He promised to look into this matter to make sure that it was really so. We at the National Coalition were troubled by the slowness of the President's recognition of homelessness as a national problem. Yet we were also cheered by the arrival of that recognition. We immediately wrote to the President offering to work with him and his administration in devising a national solution to homelessness. This was about one month ago. We have yet to receive any response.

Time and again this administration has demonstrated that it is unwilling to act. It is imperative for the United States Congress to act now.

[The prepared statement of Ms. Foscarinis follows:]

Testimony
of
Maria Foscarinis
Washington Counsel
National Coalition for the Homeless
Before the
Subcommittee on Health and the Environment
of the
Committee on Energy and Commerce
United States House of Representatives
December 15, 1986

My name is Maria Foscarinis. I am the Washington Counsel to the National Coalition for the Homeless, a federation of organizations, agencies and individuals from some 40 States and Counties accross the country committed to the principle that decent shelter, affordable housing and sufficient food are fundamental rights in a civilized society.

My testimony today is addressed to the issue of health and mental health care for the homeless. A bill covering this issue was introduced in the House earlier this year by Congressmen Waxman and Leland, the "Health Care for the Homeless Act of 1986" (H.R. 5137), and was also a part of an omnibus bill entitled "Homeless Persons' Survival Act of 1986" (H.R. 5140), cosponsored by over 60 Members of the House of Representatives. H.R. 5137 would fund local initiatives offering on-site services to the homeless. Such services would include:

(1) outpatient health care, mental health and case management services and a 24-hour emergency health service to the homeless from community-based sites;

(2) referrals of homeless individuals or families to hospitals;

(3) referrals of homeless individuals diagnosed as having communicable diseases to appropriate local public health agencies for treatment; and

(4) outreach services to inform homeless persons of available health care and benefits.

The need for adequate health care for the homeless remains critical. Indeed, as the ranks of the homeless continue to explode across the country, the health needs associated with such mass displacement threaten to assume epidemic proportions. Yet, in spite of this desperate and growing national need, virtually no Federal action has been taken to address it. We expect that legislation similar to the "Health Care for the Homeless Act of 1986," which begins to address this need, will be introduced early in the 100th Congress.

The severe medical consequences of homelessness are both obvious and extensively documented. The harsh conditions of life on the streets or in emergency shelters may cause or exacerbate illness, converting treatable conditions into serious, even fatal, disease. The plight of homeless pregnant women, receiving no prenatal care, and the plight of homeless children who have no access to pediatric care when they become ill, graphically illustrate the problem. Despite this obvious need, however, homeless persons have particular difficulty obtaining health care. Lacking

financial resources, they are usually also uninsured and "undesirable" in the view of many health care providers.

The most direct way to ensure health care for the homeless is to create community-based services appropriate to this population. Currently implemented on a small scale and temporary basis by grants from the Robert Wood Johnson Foundation, this method needs Federal funding for the scope and stability necessary to effective operation.

Special attention also needs to be given to health care for the mentally ill, an affliction which is exacerbated by the deprivation of basic human needs associated with homelessness. Homeless individuals with mental health problems are often unable, either because of their illness or because of program barriers, to obtain access to badly needed emergency services and benefits. In addition, there is a virtual absence of adequate mental health services for the homeless mentally ill. Emergency shelters generally lack the trained mental health staff necessary to identify serious psychiatric disorders and to initiate effective referrals. Existing community mental health programs cannot provide the labor-intensive and skilled work that effective outreach to the homeless mentally ill requires.

Meeting these needs and solving, or at least beginning to address, these problems require aggressive outreach that has some vestige of continuity. Homelessness is a severe and growing

problem; neglecting it can only lead to disaster . What is desperately needed are programs that can meet the special psychiatric and medical needs of homeless people, that provide services at the places where homeless people are found, and that assume the continuity of treatment that is now unavailable to them.

In addition, existing programs must be revised and expanded to insure that the homeless poor do not "fall through the cracks." Current medical assistance programs for the poor are woefully inadequate, often failing to serve the poorest of the poor such as the homeless who most desperately need them. Indeed, the present inaccessibility to and inadequacies of such programs may lead to homelessness for those living on the margin of destitution.

Finally, beyond the immediate emergency need for health and mental health care, a serious and responsible solution must include housing. Without adequate housing, even appropriate health care will provide only a temporary respite from the illnesses inevitably associated with life on the streets or in emergency shelters. And without supported housing, the mentally ill homeless will be consigned to wander abandoned on the streets of our nation.

The proposed legislation recognizes the need for adequate health care and begins to address. Because of the severity of the problem, it is imperative that Congress expeditiously consider legislation that will begin to met the health care needs of these sadly neglected people. It is no exaggeration to say that in considering this legislation Congress will be weighing a matter of life and death.

Mr. WAXMAN. Thank you very much. Let me ask you this question. Part of the reason the homeless people have so little access to health care services is that almost all of them are uninsured. Short of enacting a national health program, which the Congress is obviously not about to do, what can the Federal Government do to help pay for the needed health and mental health services of this population? Any of you may respond.

Ms. FOSCARINIS. I think we have heard this morning some very simple but also very effective steps that can be taken. Medical assistance in shelters, in other places where homeless people can be found, can be lifesaving and can provide immediate relief to homeless people. Those types of services obviously need some Federal funding to provide that assistance.

We need innovative outreach services such as those described by Ms. Sonde. Those, again, need Federal assistance. That is one way that the Federal Government can provide immediate emergency health care to the homeless.

We need to make existing programs accessible to homeless people. There are some Federal programs out there that are designed to assist the poor, such as Medicaid, but yet are not being made available to the poorest of those poor, the homeless. We need to do both of those things.

I would say beyond that though, that we do need to look at our national health care policy. A problem that was mentioned this morning was health crises or health problems actually causing homelessness. Mr. Gallagher described how, after injuring his arm, he was unable to work, unable to pay the rent, and found himself out on the streets. So I think we would need to look at health care for all poor Americans, and I think we need to think of that as a step also to solving, to stemming one of the causes of homelessness.

I don't think that is an impossible chore, Mr. Chairman. I don't think it is an impossible task. I know that you have fought the good fight for many years, and I am confident that you will not give up now to make sure that the larger issues are also addressed.

Tipper, recently you were involved in a conference on homelessness in Tennessee.

Could you share with us some of the findings of that conference?

Ms. GORE. Everything said here applies to the homeless population in Tennessee. My husband organized a statewide workshop in which he brought together major cities, eight cities participated with churches, synagogues, came together in one city to share their successes and their frustrations and also to try to get a handle on the number of homeless people in Tennessee, which number several thousand, again with the fastest growing population identified as children and then women from really a breakdown of the family, violence—I think that is something that came out that had not particularly—many people had not particularly been aware of before, the fact that family violence and spouse abuse is breaking up homes and then these women and children are going to shelters and there aren't enough shelters to take care of them.

My husband was also experiencing the fact that homeless people that seemed to display some mental illness were arriving at his Senate offices. They had no place else to go. That brings it home to the Federal Government, when the staffers have to stop and try to

figure out how to help and to find that there are major gaps in the kinds of programs that are available or that there are laws that need to be changed in order for a person in that situation to get benefits that are due them.

So the workshop was extremely helpful in networking and sharing ideas and getting a comprehensive idea of the problem of homelessness in the State of Tennessee.

I would urge that as something that other States might do, Mr. Chairman.

Mr. WAXMAN. Mr. Sikorski, any questions?

Mr. SIKORSKI. Mr. Manes, you had a response earlier to the chairman's first question.

Did you want to—

Mr. MANES. Yes. Thank you.

I think we have heard this morning of a number of excellent demonstration programs around the country sponsored by the Robert Wood Johnson Foundation and the Pew Memorial Trust and others that provide health and mental services to homeless people.

These projects, while excellent, are intermittent and fragmentary, they cannot meet the full need and were never designed to. They were designed to create models which could then be folded into a national system.

I think that is what we want to urge upon this committee today. There are plenty of good ideas and excellent ways of using nontraditional approaches to taking care of homeless people. What is missing is a national, permanent financing system.

You have it within the scope of your committee's jurisdiction to use the Medicaid program to create that—to apply the Medicaid program to establish that national financing system for homeless people who are either mentally ill or who are physically ill and that I think is the message that we want to leave with you, that the mechanism is there, the ideas are out among the health care providers and advocates.

What is lacking is some form, the way in which on a national basis these good ideas can be brought to bear on the problem.

Thank you.

Mr. SIKORSKI. Thank you.

All of you, all the panelists, Tipper and Janet, thank you.

Two things occurred to me, and I commend the chairman once again for doing this at a time when two currents are flowing in the national river.

One is, the holiday season and the wealth of our society are displayed in every direction, and we are led once again to look at our values, our morals.

The second current is the fact that we have just experienced a national election where there is going to be a refocusing of priorities.

I talked earlier about Hubert Humphrey, and he said, as he was dying of cancer, that the true moral success of any society is how we treat those in the dawn of life, our children, those in the twilight of life, our elderly, and those in the shadows of life, our homeless, our sick, our dispossessed; those without power.

Your efforts are helping us at least address the test and we will see if we can meet the test in this coming session to do something early at least to deal in the short term with this problem of homelessness and health care for the homeless.

Thank you.

Mr. WAXMAN. Thank you, Mr. Sikorski.

We commend you for your activities and for the efforts of you and your organizations. I hope that the government will meet its test and the American people will also succeed in realizing in this holiday season and carrying it over to next year that there is a value that human life must be protected, that the dispossessed and the powerless and the hungry should not be left to their own devices, but should be protected and we all have a responsibility through private charity and through our collective activities as a government to make sure that there is a true safety net helping these people to at least experience the basic minimum of human dignity.

That concludes our hearing. I hope this will raise not only the consciousness of everyone involved in this hearing, but lead to some very productive action next year.

We stand adjourned.

[Whereupon, at 11:52 a.m., the hearing was adjourned.]

[The following documents were submitted:]

TESTIMONY OF BOB PATTON

My name is Bob Patton. I was hit by a pick-up truck on June 29, 1984 in a hit and run accident and my leg was broken in eight places from my knee to my ankle. Now I'm on crutches and my leg is still in bad shape. I think it's because I didn't get the treatment I should have.

I used to be a house painter. I worked all my life. When I got hit I was living in Northern Virginia. I had my own place.

When I got hit I went to a hospital in Virginia. I spent 2½ months there.

At the hospital they put a cast on my leg. I had the cast on for 18 months because I couldn't get to see any doctor who would take it off. I went to Howard Hospital. They said I needed to get the cast off and I needed physical therapy but they wouldn't do it. I had no insurance. I wanted to take the cast off myself but I was afraid I would lose my checks if I did.

I am a veteran. I was in the service eight years. I went to the V.A. hospital and they finally took the cast off. It took them five days to take it off. They are just plain slow. You could probably lay there and die. I would sit there until they would call my name. All day I would sit there and then they would tell me to go home and then I would come back the next day and I would wait. So it took them five days to take the cast off.

While I was in the hospital I couldn't pay the rent and I lost my place. So when I got out of the hospital I went to a shelter.

Since after I got hit, I've been getting public assistance checks. About 2 or 3 months after I got out of the hospital I saved up enough to get my own place again. It was one big room in a basement and six people live in it. We had to pay $160 a month each. But I lost the place and was back on the streets because my check got cut off.

To get the check I'm supposed to take in medical reports that I couldn't work every three months. They must be there even though you might have to crawl there, you've got to get there with a report. I didn't get the report because I couldn't see a doctor. So the check was cut off.

I was on the street for three months. Then I came to the shelter. A doctor comes to this shelter once a week. He gave me the medical report. If this doctor hadn't been here, I couldn't have gotten the report so I would not have gotten my check.

Now that I'm getting my check I'd like to move out and get my own place again.

I want to move out. Before I had this accident I was working. I think that my leg is in such bad shape because the cast wasn't taken off in such a long time because no one would take it off and I didn't get physical therapy.

Clinic
1900 4th Street NW
Albuquerque, New Mexico 87102
505-242-4844

Clinic Mailing Address
Post Office Box 25141
Albuquerque, New Mexico
87125-5141

Administration
400 Walter NE
Albuquerque, New Mexico 87102
505-848-8870

ADDITIONAL STATEMENT
TO
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
THE HONORABLE HENRY A. WAXMAN, CHAIRPERSON
U. S. HOUSE OF REPRESENTATIVES
JANUARY 12, 1987

By: Richard W. Heim
Senior Vice President for Corporate Affairs
St. Joseph Healthcare Corporation
400 Walter, NE
Albuquerque, New Mexico 87102

A project of the Albuquerque Emergency Care Alliance and area hospitals
Administered by St. Joseph Healthcare Corporation

My name is Dick Heim. I am the Senior Vice President for Corporate Affairs of the St. Joseph Healthcare Corporation, a member of the Sisters of Charity Health Care Systems, which administers two acute care hospitals in Albuquerque. Our hospitals are experiencing the stresses of increased competition for paying patients and reduced reimbursement common in today's health care industry. However, although our inpatient revenue has decreased significantly, we continue our long-standing policy of denying care to no one for economic reasons and have established a trust fund, supported by donations, to help pay for medical care for Albuquerque's medically indigent.

Since serving in the Health Care Financing Administration as Director of the Medicaid Bureau from 1978 to 1981, I have witnessed the gradual reduction in the health coverage of poor Americans primarily due to the tightening up of Medicaid eligibility standards in many states and to changes in federal policy. This weakening of the national health safety net coupled with increased health care costs and the large increase in the number of the working poor has produced some discouraging statistics. Nationally, an estimated 17% of the U.S. population had no public or private health insurance in 1984. In New Mexico, which is ranked 43rd in the nation in per capita income, only 33% of those below the poverty line receive Medicaid and 25% of the population has no public or private health insurance. The most vulnerable are the homeless whose lack of basic resources, such as a permanent address, puts them outside the traditional health care system.

St. Joseph Healthcare Corporation has realized that it alone does not have the resources nor the delivery system to reach this population. However, a grant from the Robert Wood Johnson Foundation has made it possible for our organization to put our concern for the medically indigent into action.

The Albuquerque Health Care for the Homeless Project, administered by St. Joseph Healthcare Corporation in partnership with the Albuquerque Emergency Care Alliance and in cooperation with other community hospitals and human service agencies, provides primary health care of Albuquerque's homeless with the goals of allowing homeless individuals to achieve or maintain a level of health to function with the greatest self sufficiency possible and of removing health-related obstacles to overcoming homelessness. We realize that lack of jobs and affordable housing, long-term mental illness and substance abuse present formidable barriers. We support efforts to address these critical problems.

Since the project's beginning in 1985, we have served homeless patients in a donated 31-foot Airstream trailer converted into a mobile clinic which visits emergency shelters and free meals sites around the city. The trailer currently provides medical care at Salvation Army, Good Shepherd Refuge, Barrett House (a shelter for women and children) and the Shelter for Victims of Domesti Violence. Since September 1986, we also have a permanent clinic in St Martin's Hospitality Center, a daytime drop-in center for the homeless sponsored by the Espiscopal churches of Albuquerque. Funds for renovating space for this clinic came from the proceeds of Comic Relief, a celebrity comedy fundraiser in March 1986. The permanent clinic offers free medical care to the homeless Monday through Friday. The clinic and trailer serve more than 100 patients per week. Clinic staff includes a physician, a family nurse practitioner, a social worker, a project coordinator and an administrative assistant, all employees of the University of New Mexico Hospital under

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contract to St. Joseph Healthcare Corporation. The project staff use a holistic approach in caring for their homeless clients: the social worker provides counseling and referral to shelters, free meal sites, job developers, food stamp office or alcoholism treatment programs. A mental health worker, funded by a federal grant, screens our patients with signs of mental illness and provides case management services.

Since its beginning, the project has served more than 2,400 clients with such common illnesses as upper respiratory infections, traumas, and diseases of the nervous system and sense organs. Within the past week, we served a client with pneumonia and a cardiac arrest victim both requiring hospitalization.

Our project's client profile belies the public's stereotype of the typical homeless person. Our clients are 34% women, 39% members of an intact family, 13% under 14 years of age, 63% high school graduates and 67% without entitlements to public-funded programs.

Albuquerque is fortunate to be one of 18 cities to receive a Robert Wood Johnson Foundation grant to care for the homeless medically indigent. We hope to extend our $1.4 million four-year grant to a fifth year with careful spending. We also solicit contributions locally for our clients' ancillary health needs such as eye exams, glasses, and dental care. Our annual transportation budget for client bus tokens and taxis to referral sites is already exhausted. Our clients who must be hospitalized leave the hospital with no place to recuperate. Albuquerque's overcrowded shelters can take recovering homeless only through special arrangement.

The chronically mentally ill among Albuquerque's homeless provide many challenges to our staff. There are 35 beds in therapeutic residential homes for an estimated 200-300 homeless mentally ill in Albuquerque. There is one mental health worker to provide them the needed case management and many gaps in the continuum of care for this population.

As noted above, 67% of those that we have served receive no entitlements. Recent federal legislation to remove barriers to federal benefits (championed by New Mexico's Sentator Peter Domenici) are a positivie step toward improving access to these benefits.

St. Joseph Healthcare Corporation has developed a long range funding plan to assure the survival of the Albuquerque Health Care for the Homeless Project beyond the Robert Wood Johnson grant, due to end December 1989. Our plan includes philanthropic support from local hospitals, businesses and civic groups. However, we would prefer to work ourselves out of a job, that is, we prefer the goal of eliminating the causes of homelessness especially health-related causes, and would like the Federal government to be a partner in this effort. The number of health care poor in Albuquerque and in the United States is currently so large that private charitable efforts, such as the Robert Wood Johnson Health Care for the Homeless grants, and local voluntarism and charity alone will not solve the problem. We strongly support any Federal initiatives to broaden health coverage for the homeless and to improve access of the homeless to health benefits for which they are currently eligible.

ST. FRANCIS FRIENDS OF THE POOR, INC.

Testimony
of
Margaret Ann Rafferty, R.N., M.A.
Before the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives
December 15, 1986

I am Margaret Ann Rafferty, a registered nurse, author and team leader at the St. Francis Residence located at 125 East 24th Street in New York City. I am also a Member of the Board of Directors of the New York Coalition for the Homeless.

I would first like to tell a story.

Henry is living in his own room now at the St. Francis but it's been a long haul. He used to live on the streets of New York, on park benches and in doorways. He used to eat out of garbage cans. Henry stayed at New York's municipal shelter system but got beat up and moved to Grand Central Station. Henry came to the attention of the medical community when he went to a city hospital emergency room because he didn't feel well. They found him to be covered with hundreds of lice, the infestation was so bad that he had a fever of 103 degrees. He was admitted to medicine, but transferred to psychiatry when staff noticed him talking to his fingernails.

After several months of treatment he was sufficiently stabilized to come to the St. Francis. The adjustment was difficult at first; he was withdrawn - almost mute. He would sit and

watch TV all day, never change his clothes and have animated conversations with his voices. But, after six months, the combined effects of medication, supportive treatment and the stability of a home have created miracles.

Today Henry sits in our office and talks at length to the staff. He is bright, cheerful and has taken an interest in his health. If you had seen Henry before and could see him now, I'm sure that you too would agree that this is a miracle. Yet, this is not an isolated case. In my experience I have seen this happen many times. With appropriate care, the homeless mentally ill can make progress; neglected they remain hallucinating and filthy on our city streets.

Our mission at the St. Francis is simple - to provide permanent housing to the most vulnerable members of our society: the homeless mentally ill.

First, how does the St. Francis operate?

The St. Francis Friends of the Poor Inc. is a not-for-profit corporation that purchases and renovates single-room occupancy hotels. After the initial purchase and renovation costs are paid off in full, the residences are largely self-sufficient. All ordinary maintenance costs are covered by the rent payments of the tenants. The rent structure was established based on tenants ability to pay from their Federal SSI checks. Monthly rents range from $140-220 per room. Each tenant has their own room and shares a bathroom with 4 other tenants. A number of agencies collaborate to staff the St. Francis Residences.

The project is directed by three Franciscan priests who work at all three residences. Each residence has 1-1/2 registered nurses, 2 activities therapists, 1 social worker and a 1/2-time home economist. This team which is on site Monday through Friday from 9:30 AM to 4:30 PM is funded by the State Office of Mental Health and HRA CIS. Because the tenants are unable to negotiate traditional hospital clinics, the St. Francis has an attending psychiatrist who is on site daily to see tenants, handle emergencies and consult with staff. The program is also affiliated with New York University, Bellevue Hospital Center Residency Program in Psychiatry, Bellevue Hospital CSS Psychiatric Emergency Homeless Project and Bellevue Hospital Department of Social Services. Residents in their third and fourth year of training elect to spend 2 hours a week at the residence providing on-site treatment for tenants. Social workers from Bellevue provide liaison and crisis intervention services. On-site primary medical care is essential since psychiatric patients have a much higher mortality and morbidity rate than other populations. An attending physician is on site 3 hours a week to provide primary medical care. The doctor, an attending physician at the Department of Community Medicine of St. Vincent's Hospital, assists the patients to get admitted to the hospital or have necessary diagnostic work when necessary.

The St. Francis is one of the least expensive ways of caring for chronic psychiatric patients in the community. It

costs approximately $6,000 a year for a tena[nt] to live at the St. Francis. This is 1/2 the cost of a person u[sing] a municipal shelter system, 1/10 the cost of a state hos[pital] and 1/3 the cost of a state-run community residence.

The philosophy of the St. Francis [is] to provide a caring environment with enough structure so [that] persons with severe mental disabilities can live a qualit[y] life in the community. To achieve this, we blend moder[n] psychiatry with older humanitarian traditions. The staff ac[ts] as a surrogate family. The backbone of our program are act[ivities] such as poetry, art, music, writing and trips. We [all] share a communal office that has the ambiance of a kitchen. People tell jokes, do the crossword puzzle and "hang out." Tenan[ts] come into the office to get their medication, money, get [assistance] with their various entitlements or socialize. No appo[intments] are necessary and people are free to come and go. A paid [work] program encourages tenants to help with preparing meals a[t] the residence. The tenants meet weekly to air grievances.

The majority of our tenants are d[iagnosed] as schizophrenics. While some schizophrenics can be [rehabilitated] toward independent lives, this is not a realistic [goal] for the majority of our tenants. Many of our tenants have h[ad] over 20 psychiatric hospitalizations. Our goal is to prevent h[ospitalization] and improve the tenant's quality of life by pro[viding] strong social support. We have very few rules and a high [tolerance] for bizarre

behavior. The staff intervenes when a tenant's behavior becomes dangerous to himself or others. At this point, hospitalization is necessary, but hospitalizations are generally brief and we hold their room until they return.

Our program has been the recipient of numerous awards including one from President Reagan. Democrats, Republicans, Liberals, Conservatives, Advocates, mental health professionals, state and city agencies, the media and most importantly the people who live at the St. Francis give us rave reviews.

My question to this Committee is: Why can't there be more St. Francis Residences?

Why do mentally ill homeless people have to freeze to death outdoors when, for many people, a viable cost effective alternative could exist? The collapse of the low cost housing market has left the mentally ill especially hard hit. Federal legislation specifically earmarked for residential housing options for the mentally ill is a necessary first step to ending the current crisis of homelessness.

This statement is also submitted on behalf of the Staff of the St. Francis Residence:

John Felice, O.F.M.
John McVean, O.F.M.
Thomas Walters, O.F.M.
Andrew Martin, M.D.
Brian Scanlan, M.D.
Shari Urquhart, M.S., M.S.A.
Batya Leidner, B.S.N., R.N.
Janet Kreis, B.A.
John Gaines, C.W.
Emily Frank, R.N., B.S.N.
Mickey Maguire, B.A.
Robin Perl, B.A., M.S.A.
Roseanne Gaylor, M.D.
Susan Obrecht, A.C.S.W.
Michael Busch
Charles Shade
Michelle Press, M.D.
Tony Kim, M.D.
Cherie Elfenbein, M.D.
Ellen Katchur
Sister Mary Ogara
Shirley Johnson
Deborah Sullivan, R.N., B.S.N.
Louis P. Cuoco, A.C.S.W.
Gary Huth, A.C.S.W.

In addition, I am attaching, for inclusion in the record, copies of three articles, which I have co-authored, pertaining to health needs and mental health needs of homeless individuals.

PSYCHIATRIC ILLNESS AMONG THE HOMELESS

By John Talbott, M.D. and Anthony Arce, M.D.

Adapted by : Ken Thompson, M.D.

Margaret Rafferty, R.N.,M.A.

Timothy O'Connor, J.D.

A. The Magnitude of the Problem

It is clear that the homeless suffer disproportionately from psychiatric illness. The findings of several major studies suggest that one-third to one-half of the homeless have significant mental disorders(1). If diagnoses for alcoholism and substance abuse are included, the estimate for major mental disorders would rise to include nearly four-fifths of the homeless population(2).

The high prevalence of mental illness in the homeless is related to the phenomenon known as deinstitutionalization. This term refers to a series of events that began almost two decades ago that resulted in state mental hospitals releasing many patients not in need of institutional care. There were good reasons to follow a policy of deinstitutionalization. Clinically, many

people with mental disorders do not need to be in hospitals and can be taken care of in the community when appropriate supports are provided. Unfortunately, many of these patients did not receive the necessary follow-up in the community so the depopulation of the hospitals resulted in patients merely moving to the city streets, train stations and bus terminals all over the country.

A closer look at one study of psychiatric disorders among the homeless will be helpful in appreciating the depth of this health problem. During the winter of 1981, psychiatrists in Philadelphia interviewed 179 persons residing in an emergency shelter and classified each person according to psychiatric diagnosis. The following is a detailed breakdown of the results of the study by type of mental disorder:

Schizophrenia	37.4%
Alcoholism	24.6%
Personality disorders	6.7%
Affective disorders	5.6%
Organic Brain Syndrome	5%
Other mental illness	5%
No mental illness	15.6%

Thus, mental illness was diagnosed in nearly 85% of the residents(3). Although circumstances in other shelters might vary, similar diagnostic findings would probably emerge.

B. Psychiatric Assessments

Labeling a person mentally ill can sometimes stigmatize that person for life. It is therefore important to understand why mental health professionals need to make a diagnosis. Quite simply, without a correct diagnosis, an effective treatment plan cannot be made. For instance, a psychotic depression, an affective disorder, may have a much better prognosis than undifferentiated chronic schizophrenia.

While arriving at a proper diagnosis is critical, it is quite difficult to achieve for the homeless patient. Sleep deprivation, poor nutrition and poor hygiene--conditions commonly associated with homelessness--can easily affect the mental status of a homeless person. Many homeless patients who come to the emergency room may be labeled schizophrenic largely because of the way they look, when, in fact, the correct diagnosis may be a personality or affective disorder.

In medicine, a diagnosis is the result of the patient's medical history, physical examination and the results of various laboratory tests. In psychiatry, the diagnosis is based on a psychiatric interview, which

includes a thorough psychosocial history and a mental status examination, various laboratory tests, and the results of a complete medical workup. The interview is often undertaken once the practitioner has ruled out a medical reason as an explanation for the patient's behavior. This process of eliminating medical causation is crucial since a physical condition such as a brain tumor can cause a person to have a complete personality change and to act in a bizarre manner.

Taking the history of a patient is an essential part of the psychiatric examination. The practitioner needs to know what happened in the patient's life and when it happened. In addition, he/she needs to know about the progression and course of the illness. For example, are the problems in the patient's life continual or episodic? An assessment of alcoholism and drug use is also important.

During the mental status examination the practitioner makes a broad assessment of the patient's condition. Through observation and interviewing, the practitioner tries to gather sufficient and reliable information to answer a number of questions about the patient. Some of these questions might typically be the following:

1. What attitude does the patient display

generally, as well as toward the practitioner?

2. How can the patient's behavior and appearance be described?

3. What is the patient's mood and affect (how he displays the mood)?

4. What is the patient's energy level and how does that appear to relate to the patient's eating and sleeping habits?

5. What is the quality of the patient's speech, attention span, memory, and thought processes, including the ability to reason abstractly?

6. What is the patient's general orientation, i.e., does he know who he is and where he is?

7. Finally, is the patient hallucinating, i.e., seeing persons or objects and hearing voices that do not exist?

At this juncture, it would be useful to set forth a brief synopsis of a hypothetical history that might be gathered during a psychiatric interview at a shelter:

> "The subject is a woman aged 73. She was first hospitalized in a state mental facility when she was twenty-five years old. She remained there for many years during which

time she lost all contact with her family. Following her discharge, she lived in a run-down SRO hotel on Manhattan's Upper West Side. She supported herself on SSI. She rarely left the hotel and had few friends. One day, the management, desiring to close the hotel and convert it into a luxury co-op, locked her out of her room. She became confused and frightened and walked away. She has been homeless ever since then. At the shelter the subject appeared isolated and did not easily engage in conversation. She often talked to herself, apparently in response to voices she heard. She dressed bizarrely even when more appropriate clothing was available. She wore a wool hat in the summer with 22 safety pins in it. Her explanation of this during the interview was that the pins protected her "from the rays."

Based on this information and other information from the mental status examination and history, the practitioner diagnosed the patient as a chronic schizophrenic.

C. Common Psychiatric Disorders Among the Homeless

In 1980, the American Psychiatric Association published the Third Edition of the Diagnostic and Statistical Manual of Mental Disorders, known in the field as DSM-III. This 500 page book outlines the behavioral criteria for sixteen diagnostic categories. Of these major diagnostic categories, seven--schizophrenia, affective disorders, somatic disorders, personality disorders, mental retardation, developmental disabilities and organic mental disorders--are frequently encountered among the homeless. Each of these major categories will now be discussed.

Schizophrenia is the most common of all the mental disorders that afflict the homeless. While the absolute causes of schizophrenia are unknown, there is generally thought to be a genetic pre-disposition to the disease, which is brought out by environmental stresses. DSM-III lists five different types of schizophrenia, but only three types--paranoid schizophrenia, catatonic schizophrenia and chronic schizophrenia--need concern shelter workers or volunteers.

The paranoid schizophrenic is a person who has a specific delusional system that causes him/her to believe that somebody or something is out to harm him. For example, the homeless paranoid schizophrenic might live on the street because he/she thinks that if he/she stays in an apartment the FBI will get him/her. Because of these fixed belief system, to which the patient rigidly adheres, many homeless paranoid schizophrenics are very difficult to work with because they refuse all help. Generally, medication and psychotherapy is the optimal treatment for this disorder. Sometimes, however, even these will not affect the delusional system.

Catatonic schizophrenics are persons who have periods of excitement or immobility during which they exhibit random agitated behavior or complete stiffness. They may assume awkward positions for several hours, refuse to get out of bed, and remain mute. Being unable to meet basic human needs, catatonic schizophrenics find it impossible to survive outside a reasonably supportive environment, and are rarely seen in shelters.

Undifferentiated chronic schizophrenia is the third category of schizophrenia that has particular relevance to the shelter worker or volunteer. With this disease the

patient has prominent delusions, hallucinations, incoherence, and/or grossly disorganized behavior. Many homeless people in shelters will have these symptoms.

There are a number of different symptoms that schizophrenics can exhibit. A schizophrenic may lack the ability to organize his/her thoughts into a coherent pattern so that thought A leads to thought B and thought C logically flows from thought B. His/her speech may be so totally disorganized as to resemble what has been called a "word salad." For example, the patient may declare, "In the universe of concept and the red emperor grape God is dead."

Schizophrenics also have difficulty in forming interpersonal relationships and therefore tend to isolate themselves from other people. Estrangement from their family members is common. The range of mood and emotion which the schizophrenic can express is often very narrow. Whether the schizophrenic is happy or upset, he often presents the same appearance and expression.

Moreover, many schizophrenics maintain simple or elaborate belief systems which are delusional in nature and without any basis in reality. They may also have auditory

hallucinations, i.e., hear voices. Visual hallucinations are less frequent unless there is an organic (e.g., medical) problem or some intoxication due to alcohol or other drugs. For example, an alcoholic in withdrawal may experience the DT's (delirium tremens) during which he hallucinates snakes, elephants or bugs.

Not too long ago schizophrenia was thought to be a disease having an unrelenting downhill course after its onset. Recent findings from studies that gathered data from a forty-or fifty-year period are changing that perception however. These studies show that almost forty percent of patients who were first admitted to hospitals because of schizophrenic episodes had good outcomes. Unfortunately, shelter workers and volunteers will tend to see those homeless schizophrenics who have not fared as well and whose conditions have deteriorated to the point of chronic illness.

It is important for shelter workers and volunteers to form realistic goals and expectations with respect to their interaction with homeless chronic schizophrenics. In any person there is a range of behavior which may be termed normal or baseline. In the case of a chronic schizophrenic residing at a shelter the level of the "baseline" may

be quite low. A realistic goal for the shelter worker and volunteer may be to have the shelter resident get out of bed, get dressed, and tolerate sitting in a room with other people. Many of the homeless can be rehabilitated to go back to work and lead functional lives, but for the homeless chronic schizophrenic this is often an unrealistic expectation.

The number of symptoms, degree of psychosis, and length of illness define the disease's severity and longevity, e.g. as acute (short term), chronic or residual. Nevertheless, a patient with a chronic illness may still develop an acute problem. For example, a chronic schizophrenic who meets his/her essential needs by obtaining food on the street and staying at a shelter when it is very cold, may one day become extremely agitated and confused and start screaming and throwing garbage at pedestrians. It is evident then that this chronically ill person has become acutely ill and may be in need of hospitalization.

The next category of mental illness that shelter volunteers will commonly see is the affective disorders. As noted in DSM-III, the essential element of the affective disorders is a pathological disturbance in mood, e.g.,

either depression or mania, that is not secondary to any organic cause or to any other mental illness. Of all psychiatric illnesses, the evidence is strongest that people with these disorders have a genetic-biochemical predisposition to these disorders--a predisposition that can be brought out either in the presence or absence of an obvious stressor.

There are several different affective disorders classified according to symptoms. The most common psychiatric illness in the general population is that of major depression, characterized by depressed mood (much more than the feeling everyone knows as "feeling blue"), loss of interest or pleasure in usual activities such as sex or work, sleep disturbance, lack of appetite, and difficulty concentrating. Sometimes depressions are accompanied by marked anxiety and/or psychotic delusions involving guilt or physical illness (e.g., "my body is rotting inside because I'm so evil"). Suicidal thoughts are common and if the person has enough energy and the ability to carry out that intention, suicide is a real danger. In depressed persons (as with all others), the suicidal risk should be assessed by direct questions. Psychiatric referrals should be made immediately if necessary. Major depressions occur in all age groups and

in both sexes, though they are slightly more common in women. They are usually episodic and a person suffering from depression will often recover his normal level of functioning even without treatment. The number of homeless people with major depressions appears to be fewer than those with schizophrenia. This is probably due to the episodic nature of depression and also to the fact that persons suffering from depression do not tend to have their social support system broken apart. Major depressions respond well to antidepressants and electroconvulsive therapy.

In addition to having episodes of major depression, some people have manic episodes. A few have only manic episodes. Mania is characterized by a euphoric, energetic or irritable mood that is associated with hyperactivity, decreased sleep and reckless behavior. Since psychotic delusions or hallucinations are symptoms of mania, the disease can look exactly like schizophrenia or other acute psychosis. Like depression, manic episodes will usually cease over a period of time even without treatment. Usually mania first occurs before the age of thirty. It occurs equally in men and women. Manic episodes respond to antipsychotic medication and lithium. Lithium also prevents recurrences of mania.

One final comment: the prevalence of affective disorders of all types in the homeless population may be underestimated because of the high incidence of alcoholism and drug abuse, which mask an underlying affective disorder. In fact, an alcohol or drug problem may represent a person's attempt to self-medicate his depression or mania.

D. Somatoform Disorders

The somatoform disorders include the somatization disorders, conversion reactions and hypochondriasis. According to DSM-III, the unifying element of somatoform disorders is the reporting of physical symptoms suggesting physical illness for which there are no demonstrable organic cause and for which there is strong evidence of psychological dysfunction. Briefly, a somatization disorder is characterized by vague multiple symptoms or complaints for which no organic cause can be found. A conversion reaction consists of a physical dysfunction such as paralysis, that has a psychological rather than physical basis. Hypochondriasis is characterized by a fear that ordinary bodily sensations are, in fact, signs of serious illness. The prevalence of these disorders among the homeless is unknown. However, in view of the difficult

and unhealthy situations the homeless find themselves in, no physical symptom should be dismissed as psychological in origin until an organic cause is ruled out.

E. Personality Disorders

Personality traits (as described in DSM-III) are enduring patterns of perceiving, relating to and thinking about environment. If these traits are exaggerated beyond the normal range or are inflexible, they become maladaptive and dysfunctional and constitute a personality disorder. Such disorders usually manifest themselves in childhood or adolescence. The causes of the disorders are not known but present theories encompass a range of hereditary and environmental factors.

DSM-III lists 12 personality disorders. Of importance to workers with the homeless are those personality disorders which are more likely to lead a person to homelessness, e.g., any disorder which disrupts his/her social functioning or supportive social network. Chief among these are schizotypal personality, antisocial personality and borderline personality.

The schizotypal personality is best described as a strange, eccentric loner who speaks vaguely and thinks magically. If the symptoms were more pronounced or bizarre they might be considered indications of schizophrenia. Antisocial behavior, such as stealing and fighting, usually begins before the age of fifteen. In this disorder, in contrast to adult antisocial behavior (simple criminal behavior), people are more incapacitated and frequently have not spent significant periods of time outside of institutions, usually penal ones.

Persons suffering from borderline personality disorders are characterized by instability in their interpersonal relations, mood and self-image. Frequently they are demanding, impulsive, and unpredictable and suffer transient psychotic episodes.

F. Mental Retardation and Developmental Disabilities

Some homeless people suffer from global cognitive deficits, present since birth, that impair their ability to cope. It is important to try to make an assessment for the presence of retardation, since the range of services available to the mentally retarded differ from those for

the mentally ill. Developmental disabilities beginning in childhood range from hyperactivity with difficulty concentrating and poor impulse control to specific problems with reading, language or mathematics. Children who have suffered from these disabilities enter adulthood at a marked disadvantage, especially if they have received no remedial help. It is important to look into childhood functioning, whenever possible, to see if the person's adult problems are secondary to a disability that has never been appropriately recognized.

G. Organic Mental Disorders

There are a large number of organic mental disorders that present with a number of symptoms. What distinguishes organic mental disorders from other psychiatric disorders is the presence of specific cognitive symptoms and signs, e.g., difficulty concentrating, knowing where one is, or remembering, as well as a suspected physical or toxic cause. Organic mental disorders may also present in ways that mimic the other psychiatric disorders and vice versa. Several things suggest an organic causation: sudden fluctuating levels of consciousness and alertness; known impairment of memory (especially short-term memory), cognition and judgment

(dementia); recent trauma to the head or a history of seizures; and exposure to agents known to alter mental status such as alcohol, amphetamines, hallucinogens and some prescription as well as over the counter drugs. It is important to remember that if a person is delirious, without a clear explanation such as acute alcohol intoxication, he represents a medical emergency and requires immediate medical attention. If there is evidence of unexplained dementia, non-emergency medical attention is indicated to rule out reversible causes of dementia, such as vitamin deficiencies, syphilis, etc.

For a more complete description of the disorders, we refer you to DSM-III. This should provide you with a beginning understanding of some of the disorders that you will see among some homeless people during your work in the shelter.

FOOTNOTES

1. Hopper, Kim et al. One Year Later. New York: Community Service Society, 1982.

2. Arce, Anthony; Tadlock, Marilyn; Vergaree, Michael; Shapiro, Stuart. A Psychiatric Profile of Street People Admitted to an Emergency Shelter. Hospital and Community Psychiatry Vol.34 No.9: 812-817, September 1983.

3. Ibid

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5. Sheehan, Susan. "The patient: I. Creedmoor Psychiatric Center (p.49), II. Disappearing incidents (p.53), III. Is there no place on earth for me? (p.50), IV. The air is too still (p.46)," (A Reporter at Large). The New Yorker, May 25, June 1, June 8, June 15, 1981.